Supreme Court, U.S.
FILED

011586 APR 22 2002

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No. _____

In the Supreme Court of the United States

LYN EVERHART,

Petitioner,

v.

ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, DOING BUSINESS AS STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION FOR REVIEW

The Employee Retirement Income Security Act of 1974 (ERISA) establishes a uniform system of administering employee benefit plans throughout the United States. ERISA has a major impact upon the means in which employee benefits claims are resolved. Many, if not most, employee benefits are provided through the plans' purchase of insurance rather than self-funding by the employers. Although ERISA provides plan beneficiaries the right to sue when benefits are wrongly denied, the statute does not expressly define who can be sued when those benefits are provided through insurance. Each of the fifty States uniformly follows the common law principle that an intended beneficiary of an insurance policy may sue the insurance carrier without joining any other parties. The Ninth Circuit nonetheless has held, in a decision issued by a divided panel, that a beneficiary of an insured ERISA plan may not sue the insurance carrier. That ruling is at odds with the uniform practice in all States for non-ERISA insurance policies, and effectively bestows upon insurers an immunity from suit never intended by Congress in enacting ERISA.

The question presented for review is whether §502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(1)(B), authorizes the beneficiary of an insurance policy purchased under an ERISA employee benefits plan to assert a claim for benefits against the insurance carrier.

PARTIES TO THE PROCEEDINGS

Petitioner Lyn Everhart was the plaintiff and appellant in the proceedings below.

Respondent Allmerica Financial Life Insurance Company, doing business as State Mutual Life Assurance Company of America, was the defendant and appellee in the proceedings below. Respondent is also known as First Allmerica Financial Life Insurance Company. Respondent represents that it is a wholly owned subsidiary of Allmerica Financial Corporation.

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PETITION FOR WRIT OF CERTIORARI

Petitioner respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The unpublished opinion of the district court granting summary judgment is reproduced in Appendix C at 27a-34a. The opinion of the court of appeals is published at 275 F.3d 751, and is reproduced in Appendix B at 3a-26a. The unpublished order of the court of appeals denying petitioner's petition for rehearing en banc is reproduced in Appendix A at 1a-2a.

JURISDICTIONAL STATEMENT

The court of appeals entered its opinion on December 27, 2001, and denied petitioner's timely petition for rehearing en banc on February 7, 2002. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, et seq., relevant to this petition are reprinted in Appendix D at 35a-40a.

STATEMENT OF THE CASE

The employer of petitioner's husband established an employee benefit plan subject to ERISA. In accordance with the terms of the plan, the plan administrator purchased a

group life insurance policy from respondent. The terms of the policy provided that, if a plan participant died, his beneficiaries were to receive a death benefit of twice his annual earnings.

Petitioner's husband died. As the beneficiary of the policy, petitioner sought to recover the promised benefits. Respondent refused to pay the full amount of benefits. Petitioner then filed this action against respondent for recovery of benefits under § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), which provides that "A civil action may be brought (1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of the plan . . ." Thereafter, the district court granted respondent's motion for summary judgment, finding that, under ERISA, petitioner could not sue respondent for benefits. The Ninth Circuit, in an opinion by a divided panel, affirmed.

In *Harris Trust and Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238 (2000), this Court recently addressed the similar issue of determining who can be held liable for breaches of fiduciary liability under another subdivision of this same section, ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). The present case involves the related question of who can be held liable for benefits claims under § 502(a)(1)(B). Just as this Court held in *Harris Trust* that "§502(a)(3) admits of no limit . . . on the universe of possible defendants," 530 U.S. at 246, so should § 502(a)(1)(B) be understood.

Congress' express purpose in enacting ERISA was to assure a uniform administrative scheme for employee benefit plans, and to avoid the patchwork of disparate rules often resulting from variations among the states' laws. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Moreover,

"Congress authorized 'a participant or beneficiary' to bring a civil action 'to enforce his rights under the terms of the plan,' without reference to whether the relief sought is legal or equitable." *Great-West Life & Annuity Insur. Co. v. Knudson*, __ U.S. __, 122 S.Ct. 708, 718 (2002), citing 29 U.S.C. § 1132(a)(1)(B). This Court has recently recognized that, in the case of equitable claims for breach of fiduciary duty, Congress did not limit the universe of defendants subject to liability, but that Congress had focused instead "on redressing the '*act or practice* which violates any provision of [ERISA Title I].'" *Harris*, 530 U.S. at 246 (the Court's emphasis and brackets).

The claim rights of ERISA plan beneficiaries have, as interpreted by the various courts of appeals, unfortunately strayed from that purpose and resulted not only in inconsistent variations among the Circuits, but even within Circuits depending upon the panel deciding the issue. Thus, there are now three disparate lines of authority concerning who can be liable to a plan beneficiary for benefits: (1) only the benefits plan itself, *Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir. 1996); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996), (2) any party controlling the administration of the plan, *Curcio v. John Hancock Mutual Life Insurance Co.*, 33 F.3d 226, 233-235 (3d Cir. 1994); *Anderson v. Blue Cross/Blue Shield of Alabama*, 907 F.2d 1072 (6th Cir. 1990); *Garren v. John Hancock Mutual Life Insurance Co.*, 114 F.3d 186, 187 (11th Cir. 1997), and (3) in addition to the party controlling the plan, the insurer insuring the promised benefits under the plan, *Curcio v. John Hancock Mutual Life Insurance Co.*, 33 F.3d at 231-232. As part of this disarray, the Ninth Circuit has created a split within itself, with some panels holding that benefits claims are allowed only against the plan, *e.g.*, *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985), others allowing benefits

claims against the party controlling plan administration, *e.g.*, *Taft v. Equitable Life Assurance Society*, 9 F.3d 1469, 1471 (9th Cir. 1994), and still others allowing claims against the plan's insurers, *e.g.*, *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475 (9th Cir. 1997) , *aff'd sub nom.*, *Humana, Inc. v. Forsyth*, 525 U.S. 299 (1999); *Ward v. Management Analysis Company Employee Disability Plan*, 135 F.3d 1276 (9th Cir. 1998), *aff'd in part and rev'd in part on other grounds sub nom.*, *Unum Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); and *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998). The present case only exacerbates this disarray, holding that an ERISA plan's insurers cannot be sued by the ERISA beneficiaries to whom the insured benefits are owed. 275 F.3d at 756, Appendix B at 15a.[1]

The issue of who is liable to plan beneficiaries for their benefits is vitally important to employees and employers alike. A large proportion, if not a majority, of the American working public obtains employment benefits through employer-provided plans governed by ERISA. According to United States Department of Labor statistics, many of those employee benefit plans are funded by the purchase of insurance. Thus, the question of whether plan beneficiaries may sue those insurers when benefits are wrongly denied is of great importance.

REASONS FOR GRANTING THE WRIT

This case involves the single question of whether the beneficiary of an insurance policy purchased by an ERISA

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[1] The panel majority expressly acknowledged the Ninth Circuit's internal conflicts, stating that "decisions in this area may be talking past each other . . ." 275 F.3d at 756, n. 7, Appendix B at 16a.

employee benefits plan may directly sue the insurance carrier for unpaid benefits.

I. Confusion Among the Circuits

The earliest reported case apparently addressing this issue was the Ninth Circuit's 1985 opinion in *Gelardi v. Pertec Computer Corporation*, 761 F.2d 1323. *Gelardi* involved no issues of insurance, as the ERISA benefits plan was self-funded.[2] Without the benefit of any analysis, but citing ERISA §§ 502(a)(1)(B) and 502(d), 29 U.S.C. §§ 1132(a)(1)(B) and 1132(d), the Ninth Circuit stated that "ERISA permits suits to recover benefits only against the Plan as an entity . . ." 761 F.2d at 1324. That holding has been followed in subsequent Ninth Circuit cases involving self-funded plans, *see, e.g., Gibson v. Prudential Life Ins. Co.*, 915 F.2d 414, 415 (9th Cir. 1990), but has never been applied by the Ninth Circuit to an insured plan until the present case.

The *Gelardi* holding has been followed by the Second and Seventh Circuits in *Lee v. Burkhart*, 991 F.2d at 1009 (self-funded plan) and *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d at 1490 (insured plan).

The Ninth Circuit itself departed from the limitation created by *Gelardi* in *Taft v. Equitable Life Assurance Society*, 9 F.3d 1469, holding that a plan beneficiary could sue the party controlling plan administration for benefits under §

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[2] By definition, a "self-funded plan" is funded by the employer, not an insurance policy. While an insurance company may administer the plan, only the employer pays into the plan whatever funds are subsequently disbursed to pay the promised benefits. See *Lee v. Burkhart*, 991 F.2d at 1006. A self-funded plan, thus, acts in the capacity of the insurer of the promised benefits.

502(a)(1)(B). 9 F.3d at 1471. The Third, Sixth, and Eleventh Circuits have also split from *Gelardi*, joining this second line of authority that benefits claims are not limited to the plan, but can also be brought against the party controlling plan administration. *Curcio v. John Hancock Mutual Life Insurance Co.*, 33 F.3d at 233-235, n. 12 at 234; *Anderson v. Blue Cross/Blue Shield of Alabama*, 907 F.2d 1072 (holding that the policy in that case did not provide the benefits in issue); *Garren v. John Hancock Mutual Life Insurance Co.*, 114 F.3d at 187.

In a more recent third line of cases, the Ninth Circuit again departed from its earlier holdings in both *Gelardi* and *Taft*, permitting beneficiaries of insured ERISA plan to pursue benefits claims against the insurance companies insuring those benefits. *Forsyth v. Humana, Inc.*, 114 F.3d at 1475; *Ward v. Management Analysis Company Employee Disability Plan*, 135 F.3d 1276; *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939. The Third Circuit has also allowed benefits claims by plan beneficiaries against plan insurers. *Curcio v. John Hancock Mutual Life Insurance Co.*, 33 F.3d at 231-232 (holding that the policy in that case did not cover the claim in issue).

This confusion among the circuits, and even within the Ninth Circuit itself, needs to be resolved so that employees, employers, and insurance carriers will know their respective rights and liabilities in suits for benefits under insured ERISA employee benefit plans.

II. Exceptional National Importance

The U.S. Department of Labor's Bureau of Labor Statistics reports that, as of 1999, at least 53 percent of all employees in private industry participated in some type of

ERISA employee benefits plan providing for medical, dental, or vision care, retirement, or life or disability insurance. USDL 01-473, "Employee Benefits in Private Industry, 1999" (December 19, 2001) (Appendix E, p. 42a). Almost 46,000,000 employees participate in contributory medical care plans alone. (Appendix E, Table 8.) In 1996 and 1997, almost nine out of every ten employees of medium and large private sector employees were provided life insurance as an employee benefit, and more than six out of ten received that benefit from small employers. Bureau of Labor Statistics Data (Appendix F, pp. 54a-55a.) Medical care benefits were provided to about three-quarters of employees of medium and large employers and almost two-thirds of small employers, and most were funded by insurance rather than self-insured plans. (Appendix F, pp. 56a-57a.)

This case strongly implicates two important concerns of Congress in enacting ERISA: (1) "to safeguard the rights of plan participants and beneficiaries as against employers, ***insurers*** and administrators of employee benefit plans," *Emard v. Hughes Aircraft Co.*, 153 F.3d 949, 958 (9th Cir. 1998), *cert. denied sub nom.*, *Stencel v. Emard*, 525 U.S. 1122 (1999) (citing 29 U.S.C. § 1001, emphasis added), and (2) that the federal courts, informed by both state law and governing federal policies, should interpret ERISA to formulate a nationally uniform federal common law to supplement the Act. *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984). In light of the national importance of benefits delivered through ERISA plans, the decision in this case thus potentially affects the rights and remedies of millions of employees, thousands of employers, and every insurance company that contracts to provide coverage for ERISA plan benefits.

III. Necessity for Consistent Application

In *Varity Corp. v. Howe*, this Court enunciated several principles regarding ERISA that pertain to the present case. The Court recognized that a central purpose of Congress in enacting ERISA was "to offer employees ***enhanced*** protection for their benefits . . ." 516 U.S. at 497, emphasis added. In doing so, Congress "painted with a broad brush," expecting the courts to refine ERISA by developing federal common law rights, obligations, and remedies. *Id.* The Court recognized broad protections that, although discussed in the context of fiduciary duty claims, should apply here, as well:

> The statute itself says that it seeks "to protect . . . the interests of participants . . . and . . . beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries . . . and . . . providing for appropriate remedies . . . and ready access to the Federal courts." ERISA § 2(b).
>
> Section 404(a), in furtherance of this general objective, requires fiduciaries to discharge their duties "solely in the interest of the participants and beneficiaries." Given these objectives, ***it is hard to imagine why Congress would want to immunize breaches of fiduciary obligation that harm individuals by denying injured beneficiaries a remedy***.

Id. at 513, emphasis added.

One of the goals of ERISA was to assure a uniform administrative scheme for employee benefit plans, and to avoid the patchwork of disparate rules often resulting from

variations among state laws. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 9. The uniform rule of law in all States, both before and after ERISA, has always been that an intended beneficiary of an insurance contract has the right to sue the insurance company for the promised benefits. *See* Restatement (2d) Contracts, § 302(1)(b) and comm. c, illustration 4, and § 304; 17B C.J.S. § 619. There is no indication in the legislative history that Congress intended ERISA to change this consistently applied principle. To the contrary, in light of the "comprehensive and reticulated" scheme adopted by Congress in ERISA, *Nachman Corp. v. Pension Benefit Guaranty Corporation*, 446 U.S. 359, 361 (1980), it is hard to imagine that Congress would desire to immunize insurance companies from their traditional liabilities to their insureds. Such an unintended immunity would not correspond with Congress' intent to enhance employees' protection but, to the contrary, would diminish it. Moreover, such a result appears to fly in the face of Congress' express provision in ERISA for the purchase of insurance by employee benefit plans to pay the benefits promised to their beneficiaries. 29 U.S.C. § 1002(1).

This Court has recognized that Congress, in adopting § 502(a), exercised great care in delineating the universe of plaintiffs who may bring civil actions. *Harris*, 530 U.S. at 247. Ignoring that great care, however, the courts that have denied plan beneficiaries the right to sue insurers have misread and distorted Congress' intent in adopting § 502(d), 29 U.S.C. § 1132(d), as a limit on the universe of potential defendants. Section 502(d), entitled "Status of employee benefit plan as entity," provides for the benefit plan's liability for money judgments in language that does not limit the independently established liability of other potential defendants at all. On the contrary, the statute actually

recognizes the existence of a broad array of potential defendants:

> Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person ***unless liability against such person is established in his individual capacity*** under this subchapter.

§ 502(d)(2), 29 U.S.C. §1132(d)(2), emphasis added.

The statute does not, as interpreted by *Gelardi* and the panel majority in this case, restrict benefits claims only to the plan. To the contrary, the statute expressly recognizes that there can be independent "liability against [a person other than the plan]" so long as that liability "is established in his individual capacity." The clear import of that language is that, when a beneficiary does sue a plan, any money judgment it receives against the plan can be enforced only against that plan as an entity. This prevents parties from suing the plan as an entity, and then attempting to enforce a judgment obtained against the plan against either the trustees or other individuals associated with the plan. That does not bar suits against other parties responsible for paying benefits if their liability is established on an independent basis. ERISA's specific authorization for employee benefits plans to purchase insurance to fund benefits, 29 U.S.C. § 1002(1), obviously contemplates that beneficiaries will be accorded the normal and usual enforcement rights of beneficiaries of insurance in all other instances, i.e., suit against the insurer when the promised benefits are denied.

To the extent that any ambiguity in § 502(d)(2) might be interpreted to immunize plan insurers from beneficiaries'

suit to recover benefits, Congress explained its contrary intent that the statute only prevents vicarious liability for plan benefits, but not ***independent liability*** of insurers who have contracted to provide those benefits:

> Enforcement of judgment.-- The bill as passed by the House provides that a money judgment under title I of the Act against the plan is to be enforceable only against the plan as an entity and not against any other person ***unless that person's liability is established in his individual capacity***. The bill as passed by the Senate did not contain a comparable provision. Under the conference agreement the House provisions are adopted.

House Conf. Rept. No. 93-1280, 1974 U.S.Code Cong. & Admin. News 5038 at 5109, emphasis added.

Both the House and Senate Committees reported that the intent of these enforcement provisions was "***to provide the full range of legal and equitable remedies available in both state and federal courts*** and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law ***or recovery of benefits due to participants***." House Rep. No. 93-533, 1974 U.S.Code Cong. & Admin. News 4639 at 4655; Senate Report No. 93-127, 1974 U.S.Code Cong. & Admin. News 4838 at 4871, emphasis added. Congress clearly did not intend to eliminate from ERISA benefits' liability an entire class of defendants -- insurance companies -- who have consistently been held liable for promised insurance benefits in all other contexts.

Further, from an administrative standpoint, the Ninth Circuit opinion here would create an unnecessary burden on ERISA plans and their participants, as well as upon the courts. As is typical when a plan provides benefits through insurance rather than self-funding, and as occurred here with respondent, the insurer assumes responsibility for evaluating and determining the merits of claims filed by the plan's participants and beneficiaries. Although not the plan "administrator" as defined in ERISA, the insurer controls the administration of the plan and makes the discretionary decisions as to whether benefits are owed and will be paid.[3] In fact, the plan may have no assets whatsoever other than the insurance, which provides benefits payable to the beneficiaries, not the plan.

It is not difficult to conceive of an instance in which the participant sues the plan for benefits under the Ninth Circuit's scheme, receives judgment, and has no one against whom he can execute a judgment if the insurer still refuses to fund the benefits. In that case, the participant would be forced into an unnecessary second lawsuit pursuant to §502(a)(3), § 1132(a)(3), to compel the plan to pursue its legal remedies against the insurer for payment of those benefits, an unnecessary burden on each of the participant, plan, and courts. The insurance company is the party that actually controls the plan's source of funds to pay benefits -- the insurance policy -- and is thus the proper defendant.

The fact that ERISA subjects benefits disputes to concurrent state and federal jurisdiction further supports the

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[3] To be an "administrator" as that term is defined by ERISA, a person must be designated as such in the plan document. 29 U.S.C. § 1002(16)(A).

conclusion that Congress intended insurance companies to be held liable for ERISA benefits. § 502(e)(1), 29 U.S.C. § 1132(e)(1). Other than benefits claims, most ERISA civil actions are subject to exclusive federal jurisdiction. *See* §§ 502(a)-(c), 29 U.S.C. §§ 1132(a)-(c). That distinction in enforcement mechanisms is telling concerning Congress' intent to preserve the usual contract rights of insurance beneficiaries to sue their insurers:

> Moreover, Congress's choice to grant the state courts concurrent jurisdiction over this particular class of cases squares with its overall legislative goals. **Actions to recover benefits or enforce rights under the terms of a plan will typically involve the application of those *general principles of contract law* with which the state courts have had substantial experience before ERISA**; their expertise qualifies them to evaluate these rules in the light of ERISA's policies and apply federal common law.

Menhorn v. Firestone Tire & Rubber Co., 738 F.2d at 1500, n. 2, emphasis added; *accord*, *Equitable Life Assurance Society v. Crysler*, 66 F.3d 944, 948-949 (8th Cir. 1995).

Under those general principles of contract law in ***every*** state, the beneficiary of an insurance policy has the right to sue the insurer without joining any other parties. Restatement (2d) Contracts, § 302(1)(b) and comm. c, illustration 4, and § 304; 17B C.J.S. § 619. The beneficiaries' right to sue the insurers of their benefits should be no less under ERISA.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 99-17094
D.C. No. CV-99-00733-VRW

[Filed February 7, 2002]

LYN EVERHART,
Plaintiff-Appellant,

v.

ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, dba State Mutual Life Assurance Company of America,
Defendant-Appellee.

BEFORE: REINHARDT, RYMER and FISHER, Circuit Judges.

OPINION

Judge Rymer and Judge Fisher voted to deny appellant's petition for rehearing en banc. Judge Reinhardt voted to grant the petition for rehearing en banc.

The full court has been advised of the petition for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

Appellant's petition for rehearing en banc, filed January 10, 2002, is DENIED.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 99-17094

[Filed December 27, 2001]

LYN EVERHART,
Plaintiff-Appellant,

v.

ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, dba State Mutual Life Assurance Company of America,
Defendant-Appellee.

On Appeal From
United States District Court
for the Northern District of California
D.C. No. CV-99-00733-VRW
Vaughn R. Walker, District Judge, Presiding

JUDGES:
Before: Stephen Reinhardt, Pamela Ann Rymer and Raymond C. Fisher, Circuit Judges. Opinion by Judge Fisher; Dissent by Judge Reinhardt.

SUMMARY

Labor and Employment/ERISA

The court of appeals affirmed a judgment of the district court. The court held that the Employee Retirement Income Security Act (ERISA) §1132(a)(1)(B) does not permit suits against a third-party insurer to recover benefits when the insurer is not functioning as the plan administrator.

Appellant Lyn Everhart's husband was employed by Credence Systems Corporation, which established an employee benefit plan (the plan) subject to the terms of ERISA. In accordance with the terms of the plan, Credence, which was the plan administrator, purchased a group life insurance policy (the policy) from appellee Allmerica Financial Life Insurance Company. If a plan participant died, the terms of the policy dictated that his beneficiaries were to receive a death benefit of twice his annual earnings. After Everhart's husband, a plan participant, died in a plane crash, she sought twice the amount of his base salary of $84,000, plus commissions; that figure amounted to $480,000. To cover its obligation under the policy, Allmerica sent Everhart a check for about $203,000, representing twice her husband's base salary plus interest. Allmerica continued to maintain it was required to pay benefits only on Charles Everhart's base salary. Ever-hart disputed Allmerica's interpretation of the policy, and also claimed that Credence owed her husband unpaid benefits and compensation at the time of his death. Credence and Everhart entered into an agreement under which she released all claims against Credence in exchange for $230,000.

Everhart filed suit in federal district court against Allmerica for recovery of benefits under ERISA, 29 U.S.C. §1132(a)(1)(B). The district court granted Allmerica's motion for summary judgment and denied Everhart's counter-motion for summary judgment, finding that Everhart could not sue Allmerica for benefits without joining the plan as a party.

Everhart appealed.

[1] ERISA allows participants or their beneficiaries to bring a civil action to recover benefits due to them under the terms of their plan, to enforce their fights under the terms of the plan, or to clarify their rights to future benefits under the terms of the plan. However, a money judgment for an action brought under §1132(a)(1)(B) may be enforced only against the plan as an entity and is not enforceable against any other person unless liability against such person is established in his individual capacity. [2] ERISA §1132(a)(3) allows a beneficiary to bring a civil action to enjoin any act or practice which violates any ERISA provision or to obtain other appropriate equitable relief. Liability under §1132(a)(3) is not limited to the plan itself or its fiduciary. Everhart brought her suit against Allmerica under §1132(a)(1)(B), not §1132(a)(3).

[3] ERISA permits suits under §1132(a)(1)(B) to recover benefits only against the Plan as an entity. [4] However, it has also been held that claimants may bring ERISA actions to recover benefits against plan administrators. [5] Because Everhart released all her claims against the plan and the plan administrator, and limited her claim against Allmerica to a suit under §1132(a)(1)(B), she could not sue the plan's insurer for additional ERISA plan benefits. [6] Since §1132(a)(1)(B) does not permit suits

against a third-party insurer to recover benefits when the insurer is not functioning as the plan administrator, the district court properly rejected Everhart's suit.

Judge Reinhardt dissented, writing that the majority could point to no provision of ERISA either limiting the parties that may be sued under the statute to ERISA plans and administrators, or prohibiting suits against third-party insurers.

COUNSEL

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OPINION

RAYMOND C. FISHER, Circuit Judge:

Lyn Everhart appeals the district court's summary judgment in favor of Allmerica Financial Life Insurance Co. ("Allmerica"). She argues that the district court was incorrect in concluding that ERISA barred her suit against Allmerica, its employee benefit plan's insurer. Because Everhart may not bring suit to recover benefits against Allmerica in its capacity as a third-party insurer under the applicable ERISA provisions, we affirm.

I.

Appellant was married to Charles Everhart, an employee of Credence Systems Corp. ("Credence"). Credence established an employee benefit plan ("the plan") subject to the terms of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 *et seq.*, for which it was the plan administrator. In accordance with the terms of the plan, Credence purchased a group life insurance policy ("the policy") from Allmerica. If a plan participant died, the terms of the policy dictated that his beneficiaries were to receive a death benefit of twice his annual earnings.

Charles Everhart was a plan participant. In his enrollment form, he listed his annual salary as $84,800. Although this sum reflected his annual base salary, he earned a great deal more in commissions --in the last 15 months of his life he earned $193,734 in commissions, which averages out to an additional $154,987 per year. Thus, his average yearly salary, including commissions, was roughly $239,787.

Charles died in a plane crash December 5, 1994. As his beneficiary, Appellant sought twice the amount of his base salary plus commissions; rounded up to the nearest thousand (per the terms of the policy), that figure was $480,000. On September 18, 1998, Allmerica sent Everhart a check for $202,829.79 ($170,000 plus interest) to cover its obligation under the policy. It continued to maintain it was required to pay benefits only on Charles Everhart's stated salary of $84,800.

In addition to the dispute over the policy, Appellant also alleged Credence owed Charles Everhart unpaid benefits

and compensation at the time of his death. Credence and Appellant entered into an agreement March 21, 1997, under which she released all claims against Credence in exchange for $230,000.

Everhart filed this action against Allmerica February 22, 1999 for recovery of benefits under the ERISA, 29 U.S.C. §1132(a)(1)(B). Thereafter, the district court granted Allmerica's motion for summary judgment and denied Everhart's counter-motion for summary judgment, finding that Everhart could not sue Allmerica for benefits without joining the plan as a party. Everhart filed a timely notice of appeal.

II.

We review a grant of summary judgment de novo. *Balint v. Carson City*, 180 F.3d 1047, 1050 (9th Cir. 1999) (en banc). The court must determine, upon viewing the evidence in the light most favorable to the nonmoving party, whether the district court correctly applied the relevant substantive law and whether any genuine issues of material fact exist. *Id.* Interpretation of ERISA is a question of law reviewed de novo. *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643, 646 (9th Cir. 2000) (en banc).

III.

An employee welfare benefit plan is a plan an employer establishes or maintains to provide benefits for its participants. The plan provides these benefits "through the purchase of insurance or otherwise." 29 U.S.C. §1002(1).

ERISA allows participants or their beneficiaries to bring a civil action "to recover benefits due to [them] under the terms of [their] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights to future benefits under the terms of the plan." *Id.* §1132(a)(1)(B). However, a money judgment for an action brought under §1132(a)(1)(B) may be enforced "only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity." *Id.* §1132(d)(2).

Additionally, ERISA §1132(a)(3) allows a beneficiary to bring a civil action "to enjoin any act or practice" which violates any ERISA provision or "to obtain other appropriate equitable relief." Liability under §1132(a)(3) is not limited to the plan itself or its fiduciary. *Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 247, 147 L. Ed. 2d 187, 120 S. Ct. 2180 (2000) (holding that §1132(a)(3) authorizes suit against a nonfiduciary "party in interest" to a breach of fiduciary duty); *Gibson v. Prudential Ins. Co. of America*, 915 F.2d 414, 415-18 (9th Cir. 1990) (stating that insurance company that served as the plan's claims-handling agent but was not an ERISA fiduciary "cannot be sued to recover benefits or [for damages] for breach of fiduciary duty," but an "equitable remedy may have been available" under §1132(a)(3)). Everhart did not bring her suit under §1132(a)(3). She brought this action against Allmerica solely under §1132(a)(1)(B).

We held in *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985), that "ERISA permits suits [under §1132(a)(1)(B)] to recover benefits only against the Plan as an entity." Subsequent cases in this circuit have relied

on *Gelardi* to limit benefit suits to the plan. *See Gibson*, 915 F.2d at 417; *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1287 (9th Cir. 1990) (holding that inclusion of employer was improper in an ERISA suit to recover benefits). Other circuits, quoting *Gelardi*, also have held that the plan itself is the only proper defendant in a suit to recover benefits. *See Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996) ("ERISA permits suits to recover benefits only against the Plan as an entity ..."); *Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir. 1993) (same).

However, under another line of cases, in this circuit and others, claimants may also bring ERISA actions to recover benefits against plan administrators. *See Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 (9th Cir. 1993) (holding that "the beneficiary of an ERISA plan may bring a civil action against a plan administrator" to recover benefits under §1132(a)(1)(B)); *Layes v. Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998) (permitting suit under §1132(a)(1)(B) against plan administrator but not employer); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) ("The proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan.");[1] *Daniel v. Eaton Corp.*, 839

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[1] *Garren* is almost directly on point here. The benefit plan at issue was administered by the plaintiff's employer, while an outside insurance company serviced the plan. Garren sued the insurance company, arguing his employment benefit plan wrongfully denied his son's claim for benefits. The court dismissed the claim because the insurance company was not a plan administrator. *Garren*, 114 F.3d at 187 ("The evidence is clear that [plaintiff's employer] is the proper party defendant, not [the insurance company].").

F.2d 263, 266 (6th Cir. 1988) (holding that an employer is not a proper defendant in an action for benefits under ERISA unless it is "shown to control administration of a plan"). These lines of cases are summarized in *Hall v. LHACO, Inc.*, 140 F.3d 1190, 1194-95 (8th Cir. 1998).

Because Credence, and not Allmerica, was the plan administrator --a fact both parties freely acknowledge --we need not determine which line of cases more accurately states the law.[2] Appellant released all her claims against the plan and the plan administrator, and has limited her claim against Allmerica to a suit under §1132(a)(1)(B). Under either *Gelardi* or *Taft* and their respective progeny, she may not sue the plan's *insurer* for additional ERISA plan benefits.[3]

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[2] For this reason, we disagree with the dissent's contention that we should only resolve this case through an en banc proceeding.

[3] The dissent proposes a new test for suits under §1132(a)(1)(B) whereby suits for benefits could be brought against a party that is neither the plan itself nor the plan administrator, but that makes "the discretionary decisions as to whether benefits were owed." Dissent at 17345. The dissent cites no authority for this proposition. It is contrary to the cases discussed in text in this and other circuits that limit §1132(a)(1)(B) suits to plans or plan administrators, and --significantly --it seems to confuse or conflate a §1132(a)(1)(B) suit with a §1132(a)(3) suit for breach of fiduciary duty, which is not the claim Everhart is making against Allmerica. *See Gelardi*, 761 F.2d at 1325 ("ERISA defines a fiduciary of a Plan as anyone who 'exercises any discretionary authority or discretionary control respecting management of such plan or ...has any discretionary authority or discretionary responsibility in the administration of such plan' ") (quoting 29 U.S.C. §1002(21)(A)); *Gibson*, 915 F.2d at 417 (noting that §1132(a)(3) "allows equitable relief against both fiduciaries and nonfiduciaries").

Some of the Supreme Court's rationale in *Harris* may raise questions about *Gelardi's* continuing vitality. *See Harris*, 530 U.S.

Everhart argues that the pronouncements in our cases limiting actions for benefits to suits against the ERISA plan itself apply only to self-funded plans, under which the plan acts as an insurer to provide the benefits guaranteed to participants. She contends that when a plan purchases benefits from an outside insurance carrier, as here, plan beneficiaries are entitled to sue the insurance carrier to enforce their rights, as third-party beneficiaries, to collect promised benefits from the insurer.

In support of this argument, Everhart cites *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997), *aff'd*, 525 U.S. 299, 142 L. Ed. 2d 753, 119 S. Ct. 710 (1999). In *Forsyth*, a group of employee beneficiaries under an ERISA plan sued the insurance company providing health insurance for the plan. Their suit, brought pursuant to §1132(a)(1)(B), alleged the insurance company had negotiated a discounted treatment rate with a hospital but failed to pass along that discount to the plan beneficiaries in the form of lower co-payment charges. *Forsyth*, 114 F.3d at 1473. The district court granted summary judgment in favor of the plaintiffs on

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at 246 (explaining that §1132(a)(3) "admits of no limit ...on the universe of possible defendants"). But the Court also observed that" ERISA's comprehensive and reticulated scheme warrants a cautious approach to inferring remedies not expressly authorized by the text," *id.* at 247 (quotation marks omitted), and ultimately turned to the language of §1132(l) as explicitly authorizing suits for breach of fiduciary duty against a fiduciary or "other person." *Id.* at 247-48. No similar express authorization to reach third parties exists for §1132(a)(1)(B). Accordingly, *Harris* reinforces our view that the dissent's test belongs under §1132(a)(3), not §1132(a)(1)(B).

their breach of contract claim against the insurer, and this court affirmed. *Id.* at 1475.[4]

Everhart contends that in *Forsyth* the court allowed the action against the insurance company because it recognized that plan beneficiaries could sue to ensure that the insurance company would comply with its contractual obligations. Thus, she argues that the court limited, *sub silentio*, *Gelardi's* broad pronouncement that "ERISA permits suits to recover benefits only against the Plan as an entity." *Gelardi,* 761 F.2d at 1324. But there is another, simpler explanation: In *Forsyth*, Humana, the insurance company, functioned as the plan administrator.[5] Suit against Humana was therefore

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[4] The district court in this case distinguished *Forsyth* on the ground that Humana, the insurer, was a fiduciary of the plan. However, Everhart correctly notes that fiduciary status is an improper basis on which to distinguish *Forsyth* because the district court there explicitly rejected plaintiffs' attempt to bring a claim for violation of fiduciary duty: "The cause of action provided by ERISA to compensate the [plaintiffs] for the questionable conduct of Humana Insurance is a claim for benefits pursuant to §1132(a)(1)(B) and not a claim for breach of fiduciary duty under §1109 or §1132(a)(3)." *Forsyth v. Humana, Inc.*, 827 F. Supp. 1498, 1506 (D. Nev. 1993). This court specifically affirmed this portion of the district court's ruling. *Forsyth*, 114 F.3d at 1475.

[5] That Humana was understood to be the plan administrator is indicated by *Forsyth's* discussion of *Varity Corp. v. Howe*, 516 U.S. 489, 134 L. Ed. 2d 130, 116 S. Ct. 1065 (1996), decided while *Forsyth* was pending. *Forsyth* was concerned with establishing plaintiffs' standing --as individual beneficiaries --to bring not only a §1132(a)(1)(B) action, as the district court had ruled, but also a §1132(a)(3) claim for breach of fiduciary duty. *Varity Corp.* held that, under certain circumstances, individuals could bring such a claim. As the court in *Forsyth* explained:

consistent with *Taft's* interpretation of §1132(a)(1)(B) as encompassing suits against plan administrators. *See Taft*, 9 F.3d at 1471.

The distinction Everhart proposes, based on the type of plan at issue, is not compelling. Nowhere does §1132 explicitly distinguish plan types or indicate that plans utilizing outside insurance carriers permit suits against third parties whereas self-funded plans do not. Moreover, neither *Gelardi* nor *Forsyth* turns on this distinction. The statement in *Gelardi* that "ERISA permits suits to recover benefits only against the Plan as an entity" provides no indication that the type of plan is determinative in confining proper suits to those against the plan. *Forsyth* did not purport to distinguish *Gelardi* when it allowed a §1132(a)(1)(B) suit against Humana to proceed; indeed, *Forsyth* does not cite *Gelardi* at all. It may have -- with or without *Taft* in mind --extended the definition of

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> While this appeal was pending the Supreme Court issued its decision in *Varity Corp.* ...The Court held that an individual beneficiary may bring suit against *a plan administrator* for a breach of fiduciary duty under 29 U.S.C. §1132(a)(3) ... only where other equitable relief is available .... In the present case, the Co-Payors seek to recover individual relief under section 1132(a)(3) for Humana Insurance's breach of fiduciary duty. But the Co-Payors have already won a judgment for damages under section 1132(a)(1) .... In these circumstances, *Varity Corp.* does not authorize equitable relief under the catchall provision of section 1132(a)(3).

Forsyth, 114 F.3d at 1474 (emphasis added). There would have been no reason to mention that *Varity Corp.* specifically applied to "a plan administrator" if Humana was not the administrator.

permissible suits under §1132(a)(1)(B) to include actions against plan administrators, but it did not create a new rule for allowable suits premised on the type of plan funding at issue. Nor has Everhart cited any other cases to us that turn on the distinction between self-funded plans and those that purchase insurance from an outside carrier.[6]

We find no reason to depart from the established precedent of this circuit, and of every other circuit that has expressly considered the issue, that §1132(a)(1)(B) does not permit suits against a third-party insurer to recover benefits when the insurer is not functioning as the plan administrator.[7]

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[6] The dissent suggests we misconstrue plaintiff's argument, and that where third-party insurers are "legally responsible, by contract, for the making of discretionary decisions and for the payment of ERISA benefits, such parties properly can be sued under ERISA." Dissent at 17347. As we have made clear, Allmerica may well have been subject to suit were it the plan administrator or acting in a fiduciary capacity; but those are not the facts here. Indeed, Everhart did sue, and settle with, the plan administrator --Credence. On the record before us, we decline to speculate as to whether and how she might have resolved any claims she might have had against Allmerica through Credence.

[7] Although *Cisneros v. UNUM Life Ins. Co. of Am.*, 134 F.3d 939 (9th Cir. 1998), and *Ward v. Management Analysis Co. Employee Disability Benefit Plan*, 135 F.3d 1276 (9th Cir. 1998), *aff'd in part and rev'd in part*, 526 U.S. 358 (1999), might, as the dissent argues, be read as having permitted suit against an insurance company not acting as the plan administrator, neither decision addresses the issue nor makes clear what UNUM's role was under each of the plans at issue. *See, e.g., Ward*, 135 F.3d at 1288 ("Whether MAC acted as fiduciary *and as agent of UNUM in administering* the MAC Plan's long-term disability policy, particularly in receiving and forwarding claims for benefits, cannot be decided as a matter of law on the existing record.") (emphasis

Thus, we conclude that the district court properly rejected Appellant's suit.

AFFIRMED.

DISSENT

REINHARDT, Circuit Judge, dissenting:

For the reasons explained below, I respectfully dissent. The majority holds that "Everhart may not bring suit to recover benefits against Allmerica in its capacity as a third-party insurer under the applicable ERISA provisions" because "§1132(a)(1)(B) does not permit suits against a third-party insurer to recover benefits when the insurer is not functioning as a plan administrator." Maj. Op. at 17332, 17339. The majority, however, can point to no provision of ERISA either limiting the parties that may be sued under the statute to ERISA plans and administrators, or prohibiting suits against third-party insurers. Therefore, applying the reasoning of the Supreme Court in *Harris Trust and Savings Bank v. Salomon Smith Barney*, there is "no limit on the universe of proper defendants" 530 U.S. 238, 246 (2000) where the statute does not establish one. I simply cannot agree with the majority's determination to strip from Everhart and other ERISA plan beneficiaries and participants their rights under the statute to sue parties that may be liable for the payment of the benefits owed them.

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added and footnote omitted). To the extent this circuit's decisions in this area may be talking past each other, we feel bound to follow those that are explicit in their holdings.

ERISA permits a participant or beneficiary to bring suit to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. §1132(a)(1)(B). The statute does not state, as the majority claims it does, that

> a money judgment for an action brought under §1132(a)(1)(B) may be enforced "only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity. "(quoting *Id.* §1132(d))

The majority's incomplete quotation of the statute introduces a significant error into its reading. The statute actually states, in a section entitled "*Status of employee benefit plan as an entity*," that an ERISA plan may sue or be sued as an entity, *Id.* §1132(d)(1), that service of process upon a trustee or administrator of an ERISA plan constitutes service upon the plan, *Id.* §1132(d)(1), and that

> [a]ny money judgment under this subchapter *against an employee benefit plan* shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under the subchapter. (emphasis added) *Id.* §1132(d)(2)

This provision clearly applies only to suits against ERISA plans, and not to suits that may be brought against other

parties under ERISA. Contrary to the majority's implication, the provision does not limit the ability of participants or beneficiaries to bring actions against parties other than plans under §1132(a)(1)(B) or any other part of §1132. It simply makes clear that when a party does sue a plan, any money judgment it receives against the plan can be enforced only against that plan as an entity, and not against any other person, with the exception noted. This prevents parties from suing the plan as an entity, and then attempting to enforce the judgment against the individual trustees or other individuals associated with the plan.[1] The clear import of §1132(d) is to put ERISA litigants on notice that to obtain and enforce a money judgment against any party other than a plan, they must sue that other party directly. True, there may be few others who can be said to owe them the benefits, and thus few others who may be liable to suit under §1132(a)(1)(B), but as I explain below, third party insurers qualify.

Similarly, the majority misreads our precedent in *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323 (9th Cir. 1985). The facts in *Gelardi* were as follows: the ERISA plan was a self-insured plan, funded by the employer, Pertec Computer Corporation (Pertec). Self Insurance Programs (Self) was a separate corporation hired by Pertec to administer the Plan. Pertec Employee Benefits Committee was the entity to which the Plan Administrator (Pertec) had delegated

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[1] Similarly, the statute does not permit the artifice of suing a Plan's employee in his individual capacity as a means of suing the Plan. Such were the circumstances in *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996), in which the Seventh Circuit dismissed an action for denial of benefits against the Plan employee who made the benefits determination and required that the Plan itself be sued as an entity.

authority to make the final review of denied claims. There was no third party insurer involved. Gelardi attempted to sue her employer (Pertec) and the third-party administrator (Self) of the Plan. The *Gelardi* court refused to permit suit against the employer or the third-party administrator because neither, according to the operation of the plan, had discretionary control over the disposition of claims, nor were they fiduciaries. The Committee had been delegated that control. The court's language that "Gelardi must sue either the Plan or the fiduciary" must be taken within the context of the facts and circumstances of the case. What the *Gelardi* court clearly meant was that, *given the provisions of the plan at issue*, Gelardi could not sue her employer or the third-party administrator; the only parties Gelardi could sue were the parties with the authority or obligation to determine or pay the benefits --the Plan and the fiduciary. The *Gelardi* language relied on by the majority referred to an employee's right to sue under the circumstances of the particular Plan, and did not establish a general rule as to whom employees may sue under different circumstances. *Gelardi* said nothing about the existence or absence of a right of ERISA beneficiaries to sue insurance companies, let alone insurance companies that are legally responsible, by contract, for providing ERISA benefits.

Following *Gelardi*, a split developed in this circuit over whether an ERISA beneficiary could sue a third-party insurer. Two cases, *Gibson v. Prudential Ins. Co.*, 915 F.2d 414, 417 (9th Cir. 1990), and *Madden v. ITT Long Term Disability Plan for Salaried Employes*, 914 F.2d 1279, 1287 (9th Cir. 1990), held, without reasoning, but citing *Gelardi*, that ERISA beneficiaries could sue only plans or fiduciaries of plans. Three cases, *Forsyth v. Humana, Inc.*, 114 F.3d

1467 (9th Cir. 1997), aff'd, 525 U.S. 299, 142 L. Ed. 2d 753, 119 S. Ct. 710 (1999), *Ward v. Management Analysis Company Employee Disability Benefit Plan*, 135 F.3d 1276 (9th Cir. 1998), *Cisneros v. UNUM Life Insurance Company of America*, 134 F.3d 939 (9th Cir. 1998), affirmed the rights of ERISA beneficiaries to sue third-party insurers by permitting suits against such insurers to proceed. Because of this intra-circuit split, the proper course for us to follow would be to request that the case be heard en banc.[2] Because the majority declines to do so, I will explain here why, were we free to disregard the conflict and decide the case from scratch, I would hold that an ERISA beneficiary may sue a third-party insurer who is legally responsible, by contract, for the payment of ERISA benefits.

The "recovery of benefits" provision of ERISA permits participants or their beneficiaries to sue only to recover benefits. Under this provision, plaintiffs are not permitted to receive punitive relief or damages. In this sense, recovery under the provision is akin to equitable relief ordering payment of unpaid benefits, and the Court's reasoning in the recent *Harris* decision is particularly applicable. 530 U.S. 238. In *Harris*, the Court found that §1132(a)(3), permitting equitable relief to redress a violation of the fiduciary's duty to refrain from certain transactions

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[2] The intra-circuit split discussed in the majority opinion --whether only the plan itself may be sued or whether plan administrators may also be sued --demonstrates the confusion and disagreement in our case law on the question of standing under the ERISA provision at issue. Maj. Op. at 17334-35. It provides further support for the argument that the instant case should not be resolved by this panel but by an en banc court.

with "parties in interest," did not contain a limit on defendants because it was meant as a broad remedy of redress, and because the statutory provision expressed no limit on possible defendants. 530 U.S. at 246-47. Similarly, §1132(a)(1)(B) was intended as a broad remedy of redress, and contains no explicit limit on possible defendants; therefore, no such limit should be read into it. For this reason, both parties that legally owe the benefits and parties that have the legal power to determine or pay those benefits because they administer them, are proper party defendants in an ERISA suit under §1132(a)(1)(B).

The extensive line of cases permitting suits against plan administrators supports the proposition that ERISA does not limit §1132(a)(1)(B) suits to suits against the plans themselves, but permits suit against parties responsible for providing or administering ERISA benefits and making discretionary decisions as to whether benefits were owed. *See Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 (9th Cir. 1983) ("The beneficiary of an ERISA plan may bring a civil action against a plan administrator ..."); *see also Hall v. LHACO, Inc.*, 140 F.3d 1190, 1194 (8th Cir. 1998) ("The proper party against whom a claim for ERISA benefits may be brought is the party that controls administration of the plan, not the plan participant's employer." (quotations omitted)); *Layes v. Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998) (citing *Garren* and permitting suit against insurer but not employer, because insurer was "at all relevant times the sole administrator of the long-term disability plan offered by [employer]"); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) ("The proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan."); *Daniel v. Eaton*

Corp., 839 F.2d 263, 266 (6th Cir. 1988) (holding that the pension committee which was "responsible for administering and interpreting the plan and was solely responsible for a denial of benefits" was therefore "the only proper defendant in an action concerning benefits"). In this case, Allmerica, as the third-party insurer, was responsible for evaluating and determining the merits of claims filed by the plan's participants and beneficiaries. It controlled the administration of the plan and made the discretionary decisions as to whether benefits were owed. Therefore, although not the plan administrator, it can properly be sued under ERISA.

A party that is legally responsible for paying ERISA benefits can also properly be sued under §1132(a)(1)(B). That third-party insurers in particular can be sued when they are legally responsible, by contract, for the payment of ERISA benefits is confirmed by several cases in this circuit in which ERISA beneficiaries have been permitted to bring suit against third party insurers under that provision. In *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997), *aff'd*, 525 U.S. 299, 142 L. Ed. 2d 753, 119 S. Ct. 710 (1999), class members comprised of employee beneficiaries brought a claim for recovery of benefits under §1132(a)(1)(B), contending that the third-party insurer of their plan had breached its contract with them by negotiating a discount with a hospital and not passing the discount along to them. We upheld the district court's grant of summary judgment in the plaintiffs' favor against the insurer under §1132(a)(1)(B). The Supreme Court, in an opinion by Justice Ginsburg for a unanimous court, affirmed our decision. The majority contends that the suit against the third party insurer was allowed to proceed in *Forsyth* only because the insurance company functioned as the plan administrator. There is

nothing in *Forsyth* to support either my colleagues' factual assumption or their legal conclusion. The contention that it is "clear" from *Forsyth's* discussion of *Varity Corp. v. Howe,* 516 U.S. 489, 134 L. Ed. 2d 130, 116 S. Ct. 1065 (1996), that Humana was understood to be the plan administrator is patently incorrect. *Varity Corp.* was a case, like many cited by the majority, in which the ERISA plan at issue was self-funded, and the employer served as the plan administrator. There was no third-party insurer in *Varity Corp.*; therefore, the *Forsyth* court could not possibly have viewed the facts as being analogous. In fact, it is" clear" that *Forsyth* cited *Varity Corp.* on an entirely different point. It cited *Varity Corp.* for the proposition that a suit could not be brought under §1132(a)(3), the "catchall" fiduciary duty provision, when relief was already available under §1132(a)(1)(B); then, because relief was available against the insurer under §1132(a)(1)(b), *Forsyth*, relying on *Varity Corp.* denied a similar "catchall" claim.

I would also point out that at no point in the Supreme Court decision, the appeals court decision, or the district court decision in *Forsyth* is it held, asserted, suggested or even implied that Humana was the plan administrator. The majority's distinguishing of *Forsyth* on that basis is simply unsupportable. The relevance of *Forsyth* to the issue before us is that the suit was allowed to proceed because in that case, as in this, the third-party insurer was *legally responsible for paying the ERISA benefits the plaintiffs sought to recover.* Moreover, in at least two other instances, this circuit has permitted ERISA beneficiaries to sue third-party insurers. In *Cisneros v. UNUM Life Insurance Company of America*, 134 F.3d 939 (9th Cir. 1998), the ERISA beneficiary was permitted to sue the third party insurer for the recovery of

benefits despite the fact that the insurer was not the plan administrator and neither the plan nor the plan administrator were named as defendants. Finally, in *Ward v. Management Analysis Company Employee Disability Benefit Plan*, 135 F.3d 1276 (9th Cir. 1998), an ERISA participant was also permitted to sue the insurer for the recovery of benefits, even though the insurer was not the plan administrator and even though the participant was not permitted to sue the employer who established the plan.

The majority misconstrues the distinction the plaintiff claims is made under the statute between suits against self-funded plans and suits against plans that purchase benefits from a third-party insurer. The distinction that exists in the ERISA scheme and the cases is based on this: One can legitimately sue an entity that is legally responsible for the payment of ERISA benefits or one that makes the discretionary decisions as to those benefits. In the case of self-funded plans, it is likely that few third parties will meet this standard, hence *Gelardi's* holding that Gelardi could sue only "the Plan or a fiduciary." In the case of plans in which a third party, such as an insurer, is legally responsible, by contract, for the making of discretionary decisions and for the payment of ERISA benefits, such third parties properly can be sued under ERISA.

Finally, permitting suits such as Everhart's furthers the policies of ERISA, and is consistent with our duty to develop a body of federal common law applicable to ERISA." Under ERISA, Congress has authorized the courts 'to formulate a nationally uniform federal common law to supplement the explicit provisions and general policies set out in [the Act].'" *Sec. Life Ins. Co. of Am. v. Meyling*, 146 F.3d

1184, 1191 (9th Cir. 1998) (quoting *Peterson v. Am. Life & Health Ins. Co.*, 48 F.3d 404, 411 (9th Cir. 1995)) (alteration in original). In formulating the federal common law applicable to ERISA, courts are to be "governed by the federal policies at issue." *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1500 (9th Cir. 1984). The stated Congressional policy of ERISA is to "protect the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. §1001(b) (congressional findings and declaration of policy). Specifically, Congress sought through ERISA to protect plan participants and beneficiaries "as against employers, *insurers* and administrators of employee benefit plans." *Emard v. Hughes Aircraft Co.*, 153 F.3d 949, 958 (9th Cir. 1998) (citing 29 U.S.C. §1001 (Congressional findings and policy)) (emphasis added). It is consistent with this policy to permit suits against any party that "controls administration of a plan "or is legally responsible for the payment of ERISA benefits, as this circuit has implied in numerous cases permitting ERISA beneficiaries to sue plan administrators and third-party insurers. To leave an ERISA beneficiary such as Everhart without a remedy against the very party that has deprived her of her interest in her late husband's ERISA plan by refusing to pay the benefits she seeks to recover would be directly contrary to the stated policy of the statute.

Normally under state common law, insurers such as Allmerica can be sued by parties, such as Everhart, who qualify as third-party beneficiaries, *see Restatement (Second) of Contracts* §302(1)(b) and comm. c, illustration 4, and §304 (1979); 46A C.J.S. Insurance §1520 et seq. In developing a federal common law to govern ERISA suits, courts are expected to "refer[]to [and] be[]guided by principles of state

law." *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1500 (1984). *See also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989). I would adopt the state common law regarding third party beneficiaries and incorporate it into federal common law for purposes of ERISA. The responsibilities owed by an insurer to the beneficiaries of the policies it sells should not be diminished simply because the policy at issue is a Plan's way of administering employee benefits. It would further the purposes of ERISA for participants and beneficiaries to be permitted to vindicate their claims against insurers under the statute and to recover from them the benefits they are owed.

There is no statutory prohibition in ERISA on suits against third-party insurers, nor is there a provision in the statute limiting ERISA suits to those against plans as entities. There is, however, significant authority in our circuit permitting suits against third-party insurers. Allowing ERISA beneficiaries such as Everhart to vindicate their ERISA rights against those responsible for the resolution of claims and for the payment of benefits is consistent with the core purposes of the statute. Under these circumstances, were this panel free to decide the issue despite the intra-circuit split, I would hold that Everhart has standing to pursue her suit against Allmerica. In short, I would uphold her right to recover the benefits owed her as an ERISA beneficiary, as the statute intends.

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

CASE NUMBER: C99-0733 VRW

[Filed July 9, 1999]

LYN EVERHART, Plaintiff, v. ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, d/b/a STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA, Defendant.	)

JUDGES:
VAUGHN R. WALKER, United States District Judge.

ORDER

Plaintiff filed this action under the Employment Retirement Income Security Act ("ERISA") §502(a)(1)(B), 29 USC §1132(a)(1)(B), for recovery of benefits due upon a life insurance policy provided under an ERISA employee benefit plan. Pending before this court are cross-motions for

summary judgment or in the alternative, for partial summary judgment. The court finds these motions appropriate for decision without oral argument. *See* Civil LR 7-11(c). The hearing scheduled for July 9, 1999, at 10:30 a.m. is therefore VACATED.

Summary judgment is a method for the prompt disposition of an action in which there is no genuine issue of material fact. FRCP 56(c) provides for the granting of summary judgment where the moving party is entitled to judgment as a matter of law. The burden of establishing that there is no genuine issue of material fact lies with the moving party. *Celotex Corp v Catrett*, 477 U.S. 317, 322-23, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986). Where the nonmoving party will bear the burden of proof at trial, the moving party may meet its burden by pointing out the absence of evidence to support the nonmoving party's case. *Celotex*, 477 U.S. at 325. A conclusory statement asserting an absence of evidence will not suffice to meet this standard; the lack of evidence must be demonstrated. *Id* at 326. Once the moving party has met its burden either by presenting evidence which, if uncontradicted, would entitle it to a directed verdict at trial or by demonstrating the lack of evidence for the nonmoving party's case, FRCP 56(e) shifts to the nonmoving party the burden of presenting specific facts showing a genuine issue for trial. *British Airways Bd v Boeing Co*, 585 F.2d 946, 950-52 (9th Cir 1978).

A party opposing summary judgment may not rest upon the mere allegations or denials of his pleadings. Rather, responses, either by affidavits or as otherwise provided in the rule, must set forth specific facts showing that there is a genuine issue of fact. A mere "scintilla" of evidence

supporting the nonmoving party's position will not suffice. There must be enough of a showing that the jury could reasonably find for the nonmoving party. *Anderson v Liberty Lobby, Inc*, 477 U.S. 242, 248, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986).

The question in summary judgment motions is whether reasonable minds could differ as to the import of the evidence. *Eisenberg v Insurance Co of North America*, 815 F.2d 1285, 1288 (9th Cir 1987). "If the evidence is merely colorable * * * or is not significantly probative, summary judgment may be granted." *Id* at 1288. The nonmoving party's evidence is to be taken as true and all inferences are to be drawn in the light most favorable to the nonmoving party. *Eisenberg*, 815 F.2d at 1289.

Plaintiff was married to Charles Everhart who was an employee of Credence Systems Corporation (Credence). Credence created an employee benefits plan pursuant to ERISA. The plan provided a life insurance policy to Charles as an employee. The life insurance policy was purchased as part of a group plan from defendant Allmerica. Credence was named in the policy as the plan administrator and fiduciary. The policy provides that benefits will be payable in the sum of "two times basic annual earnings." Annual earnings are defined in the policy as "compensation, including commissions and bonuses." Plaintiff is the beneficiary of the policy.

On December 5, 1994, Charles was killed in an airplane accident. In correspondence to plaintiff, defendant stated that the amount of life insurance benefits payable would be $170,000. This figure reflected twice the amount of

Charles' annual earnings of $84,800 as reported on his benefit enrollment form, then rounded up to the nearest $1000 as per the policy. The $84,800 amount reflects Charles' base salary. Upon investigation, plaintiff discovered Charles' actual annual earnings, including commissions and bonuses, was $240,000. Plaintiff advised defendant of this fact and demanded that it pay the amount of $480,000, twice the amount of Charles' actual annual earnings.

Meanwhile, a dispute arose between plaintiff and Credence over unpaid compensation and benefits owed to Charles at the time of his death. Consequently, plaintiff received a $230,000 settlement in return for a written release of all claims against Credence, including any ERISA claims.

In September 1998, defendant delivered to plaintiff $170,000 plus interest as payment of the benefits payable under the policy. Defendant agreed that plaintiff's acceptance of such payment would not waive any claim by her for any additional benefits under the policy. In November 1998, plaintiff demanded defendant pay to her the balance of benefits due under the policy, amounting to $310,000, the difference between the $170,000 paid and the $480,000 to which plaintiff claimed she was entitled. Defendant claimed it was not liable for any additional payment of benefits. In response, plaintiff filed a complaint for recovery of benefits. Subsequently both parties filed cross-motions for summary judgment.

Defendant's motion for summary judgment alleges: (1) plaintiff's suit is barred by ERISA which only permits a suit against the employee benefit plan itself--not the plan's insurer, (2) plaintiff has released any claim she could possibly bring

against defendant, (3) recovery of additional benefits would sanction a fraud and (4) plaintiff's claim is barred because she failed to exhaust her administrative remedies. The court finds it necessary to address only the first allegation.

Defendant correctly maintains that "ERISA permits suits to recover benefits only against the Plan as an entity." *Gelardi v Pertec Computer Corp*, 761 F.2d 1323, 1324 (9th Cir 1985); *see also Gibson v Prudential Ins Co of America*, 915 F.2d 414, 417 (9th Cir 1990)(quoting *Gelardi*, 761 F.2d at 1324-25); *Madden v ITT Long Term Disability Plan*, 914 F.2d 1279, 1287 (9th Cir 1990)(also quoting *Gelardi*, 761 F.2d at 1324-25); *Mann v New England Mut Life Ins Co*, 1991 U.S. Dist. LEXIS 999, 1991 WL 631954, *3 (ND Cal 1991) ("§1132(a)(1)(B) permits suits to recover benefits only against the Plan as an entity * * * and not against an employer or insurer"); *Lambert v Pacific Mut Life Ins Co*, 211 Cal. App. 3d 456, 461, 259 Cal. Rptr. 398 (1989) (affirming trial court's dismissal of claim against insurer for denial of benefits on ground that plan, not plan's insurer, was proper defendant); *Cohen v Equitable Life Assurance Soc'y*, 196 Cal. App. 3d 669, 672, 242 Cal. Rptr. 84 (1987) (suit to recover benefits under ERISA plan may be brought only against plan as an entity); *Roeder v Chemrex Inc*, 863 F. Supp. 817, 828 (D Wis 1994) (dismissing claims against plan insurer on basis that "[a]n ERISA Plan is the only proper defendant when a claim is made for benefits * * *"); *Auto Club Ins Ass'n v Safeco Life Ins Co*, 833 F. Supp. 637, 643 (WD Mich 1993) (dismissing suit against insurer on basis that "[t]he proper defendant in a suit to recover benefits is the Plan").

To support her position, plaintiff cites *Forsyth v Humana, Inc*, 114 F.3d 1467, 1475 (9th Cir 1997), a recent

case which allowed plaintiffs to state a benefits claim for breach of contract against an insurance company. In Forsyth, the insurer negotiated a discount with a hospital, an act which the court determined "constituted discretion in the administration of a plan." *Id* at 1505. Such discretion rendered the insurer a fiduciary of the plan. *Id*. As a plan fiduciary, the insurer, normally insulated from ERISA claims, could be sued for recovery of benefits.

Unlike the insurer in *Forsyth*, the defendant in this case is not a fiduciary of the plan. The policy explicitly states that the fiduciary is the plan administrator, Credence. *See* Stipulation as to Mat'l Facts, Ex A, ERISA notice, ¶ 14. The holding in *Forsyth* is therefore not applicable to the facts of this case.

Because the plan, not the insurer, is the proper party to sue to recover benefits in an ERISA claim, plaintiff's only avenue for recovery of benefits is to sue the plan, Credence. Plaintiff, however, signed an agreement releasing Credence from any further liability and is therefore precluded from pursuing that avenue.

CONCLUSION

For the foregoing reasons, defendant's motion for summary judgment (Doc 7) is GRANTED. The clerk shall enter judgment, close the file, and terminate all pending motions.

IT IS SO ORDERED.

/s/_____
VAUGHN R. WALKER
United States District Judge

District Court Order and Judgment - 7/9/99

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

CASE NUMBER: C99-0733 VRW
[Filed July 12, 1999]

LYN EVERHART,
Plaintiff,

v.

ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, d/b/a STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA,
Defendant.

JUDGES:
VAUGHN R. WALKER, United States District Judge.

JUDGMENT IN A CIVIL CASE

IT IS ORDERED AND ADJUDGED

For the reasons stated in the accompanying order of dismissal, judgment is entered.

The Clerk shall close the file.

APPENDIX D

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I-PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE A--GENERAL PROVISIONS

§1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

***

(16)(A) The term "administrator" means--

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I-PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B--REGULATORY PROVISIONS
PART 5--ADMINISTRATION AND ENFORCEMENT

§1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021 (f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or

(B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the

time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

***

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021 (f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

***

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

APPENDIX E

NEWS

United States Department of Labor

Bureau of Labor Statistics Washington, D.C. 20212

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USDL: 01-473

FOR RELEASE: 10:00 A.M. EST
WEDNESDAY, DECEMBER 19, 2001

Employee Benefits in Private Industry, 1999

Paid time off was the most prevalent benefit available to workers in private establishments in 1999. Paid vacations were offered to 79 percent of employees and paid holidays to 75 percent, according to the Bureau of Labor Statistics, U.S. Department of Labor. The new National Compensation Survey (NCS) provides more detailed data on benefits by selected worker and establishment characteristics than

previously available. The next release on benefits, scheduled for the spring of 2002, will contain 2000 data with details of benefit plan provisions, as well as incidence information.

The NCS provides comprehensive measures of occupational earnings, compensation cost trends, and details of benefit provisions. The focus of this summary is on the incidence of employee benefits, ranging from health and retirement benefits to wellness programs; it also includes data on employee contributions to medical care plans. (See the technical note for definitions of incidences.)

Fifty-three percent of employees in private industry participated in medical care plans, and 48 percent were covered by retirement benefits of at least one type, either a defined benefit plan (21 percent) or a defined contribution plan (36 percent). (Approximately 9 percent of employees were enrolled in both types of plans.) Paid sick leave and life insurance were available to over half of all employees in private industry. Short- and long-term disability insurance benefits were less common: they were available to 36 and 25 percent of employees, respectively. Other benefits frequently offered in private industry include non-production bonuses (offered to 42 percent of employees) and work-related educational assistance (available to 41 percent). Employee assistance programs and Section 125 cafeteria plans were not uncommon; both were available to around one-third of employees. (See technical note for definition of Section 125 plans.) Severance pay and job-related travel accident insurance were available to about one-fifth of employees.

Fully paid medical care coverage was provided to 33 percent of participants in single coverage plans and 19 percent

in family coverage plans. The majority of medical plan participants were required to contribute a flat monthly amount, averaging $48.30 for single and $169.84 for family coverage.

Access to most benefits, availability of fully paid medical care, and the amount of required contributions to the cost of medical care varied by worker and establishment characteristics, as well as by region.

Data in this summary are a subset of the benefits data tabulated for the National Compensation Survey. Tables 1-5 highlight incidence of coverage for employee benefits by worker and establishment characteristics as well as by geographic area. Tables 6-8 show data on employee contributions to medical care.

Worker characteristics

Benefits coverage varied by occupational group, full- and part-time status, and union and nonunion status. Of the three occupational groups for which data are presented in this release, professional, technical, and related employees had the greatest incidence of coverage for all of the major benefits. The difference was especially significant in the coverage for paid sick leave benefits: 81 percent of professional, technical, and related employees were covered, compared with 59 percent of clerical and sales employees and only 38 percent of blue-collar workers. (See table 2.) Retirement benefits were offered to about 7 out of 10 professional, technical, and related employees, compared with fewer than half of clerical and sales and blue-collar and service employees (45 and 42 percent, respectively). (See table 1.)

Payment of premiums for medical care coverage also varied by employee characteristics. Blue-collar and service workers with medical care benefits had their health care coverage fully paid for by their employers more often than workers in the other two groups: 37 percent of blue-collar workers with medical care benefits had fully paid single coverage, compared with 31 percent of professional, technical, and related employees and 29 percent of clerical and sales employees. Fully paid single medical coverage also was more prevalent among union employees - 52 percent with medical care benefits had fully paid single coverage, compared with 30 percent of non-union employees. Blue-collar and service employees, however, had the highest average fiat monthly contributions to medical care plans; these contributions averaged $50.67, compared with $47.70 for clerical and sales employees and $45.34 for professional, technical, and related employees. Average contributions for single coverage among union and non-union employees were almost the same. For family coverage, the average required contribution for union employees was about $45 per month less than for their non-union counterparts. (See table 6.)

Full-time employees were much more likely to have benefits coverage than were part-time employees. Fifty-six percent of full-time employees were covered by retirement benefits, compared with 21 percent of part-time workers. The difference in participation in health care benefits was even greater: 64 percent of full-time employees were covered by medical care plans, compared with only 14 percent of part-time workers. (See table 1.) Availability of fully paid medical benefits also was greater among full-time workers; 34 percent of those with medical benefits were not required to contribute for single coverage, compared with 22 percent of part-time

workers. Where average flat monthly contributions were required, part-time workers' contributions for single coverage were about $10 higher per month than those of full-time workers; for family coverage, part-time workers had to pay, on average, nearly $24 more per month. (See table 6.)

Establishment characteristics

Benefit incidence varied most by establishment employment size. Workers in the smallest establishments were much less likely to be covered by health or retirement benefits than their counterparts in establishments employing 2,500 workers or more. For example, 30 percent of workers in establishments with 1 to 49 employees had a retirement plan, compared with 81 percent of workers in establishments with 2,500 or more employees. Life insurance benefits also were much less prevalent in the smallest than in the largest establishments. The difference in coverage for paid time off benefits was smaller: 82 percent in the largest establishments had paid holiday benefits, for example, compared with 66 percent in the smallest establishments. (See table 3.) Workers in medium-sized establishments (those employing between 100 and 1,000 workers) were less likely to be offered major benefits than those in larger establishments but were more likely than those in the smallest-sized establishments. The incidence of fully paid coverage for medical care, however, decreased with establishment size, from 46 percent of those with medical care benefits in the smallest class to 19 percent in the largest class for single coverage, and from 27 to 17 percent for family coverage. Average monthly employee contributions varied by establishment size, but not proportionally.

Coverage for benefits also varied by industry. Goods-producing industries had a higher incidence of coverage for many benefits than service-producing industries. Medical care and retirement benefits were less prevalent in service-producing industries: 48 and 44 percent, respectively, compared with 69 and 61 percent in goods-producing industries. Coverage patterns were mixed, however, for disability benefits. Paid sick leave was much less prevalent in goods-producing industries (42 percent had such coverage) than in service-producing industries, where 57 percent of employees had coverage. Short-term disability benefits, in contrast, were available to almost half of employees in goods-producing industries, while only about one-third of employees in service-producing industries had such coverage. (See table 2.)

Geographic regions

Incidence of benefits varied also by establishment location, although differences were generally small. Rates of coverage tended to be higher in the Northeast and Midwest than in the South and the West, although the differences were not consistent for all benefits. Fifty-three percent of workers in the Northeast and Midwest were covered by retirement benefits, compared with 47 percent in the West and 43 percent in the South. Medical care plans covered 54 percent of workers in all the regions, with the exception of the South, where the incidence was 51 percent. Paid sick leave was less prevalent in the Midwest, whereas short-term disability coverage was much more prevalent in the Northeast, in part because it is mandated in New York and New Jersey. Paid vacation benefits were fairly uniform across the regions, and

paid holidays were slightly more common in the Northeast than in the other regions.

Variations by region also occurred in the incidence of fully employer-paid coverage of medical care benefits and in amounts of employee contributions required. Workers in the West enjoyed the highest incidence of fully paid medical care benefits, for both single and family coverage. Workers in the Northeast were the least likely to have fully employer-paid single coverage, and workers in the South had the lowest incidence of fully employer-paid family coverage. Workers in the Midwest and West were required to pay the lowest monthly contributions for single coverage ($42.33 and $42.50 on average, respectively), while in the Northeast and South these contributions averaged over $50. The required average monthly contributions for family coverage were the lowest in the Midwest ($144.99) and the highest in the South ($187.46).

Bureau of Labor Statistics News

FOLD OUT EXHIBITS

TABLES 1-8

"NEWS - UNITED STATES DEPT. OF LABOR BUREAU OF LABOR STATISTICS"

Table 1. Percent of workers participating in retirement and health care benefits by selected worker and establishment characteristics, private industry, National Compensation Survey,[1] 1999

Characteristics	Retirement benefits			Health care benefits		
	All	Defined benefit	Defined contribution	Medical care	Dental care	Vision care
Total	48	21	36	53	32	18
Worker characteristics:[2]						
Professional, technical, and related employees[3]	69	29	56	68	49	30
Clerical and sales employees[3]	45	17	34	51	30	14
Blue-collar and service employees[3]	42	21	28	48	27	15
Full time	56	25	42	64	39	22
Part time	21	9	14	14	10	6
Union	79	70	39	73	52	39
Nonunion	44	16	35	51	30	15
Establishment characteristics:						
Goods-producing[4]	61	36	43	69	39	21
Construction	39	18	25	55	26	14
Manufacturing	68	42	49	74	44	24
Service-producing	44	17	34	48	30	17
Transportation and public utilities	59	39	46	57	40	22
Wholesale trade	53	18	44	67	36	19
Retail trade	30	11	22	31	17	8
Finance, insurance, and real estate	62	32	53	66	51	23
Services	45	14	33	50	32	19
1-99 workers	34	8	27	46	23	12
1-49 workers	30	7	24	41	19	9
50-99 workers	49	12	39	63	40	23
100 workers or more	64	37	46	61	43	25
100-499 workers	57	25	41	58	37	18
500-999 workers	70	48	43	64	47	27
1,000-2,499 workers	70	42	48	62	42	30
2,500 workers or more	81	66	64	71	57	40
Regions:[5]						
Northeast	53	26	38	54	35	21
South	43	18	32	51	27	13
Midwest	53	27	39	54	32	17
West	47	17	35	54	39	25

[1] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[2] Employees are classified as working either a full-time or part-time schedule based on the definition used by each establishment. Union workers are those whose wages are determined through collective bargaining.

[3] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[4] Includes data for mining not shown separately.

[5] The regional coverage is as follows: Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; South—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; and West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

NOTE: Where applicable, dash indicates no employees in this category.

Table 2. Percent of workers participating in survivor and disability benefits by selected worker and establishment characteristics, private industry, National Compensation Survey,[1] 1999

Characteristics	Survivor benefits			Disability benefits		
	Life insurance	Accidental death and dismemberment	Survivor income benefits	Paid sick leave	Short-term disability	Long-term disability
Total	56	43	3	53	36	25
Worker characteristics:[2]						
Professional, technical, and related employees[3]	76	61	5	81	49	48
Clerical and sales employees[3]	54	38	2	59	33	26
Blue-collar and service employees[3]	48	37	3	38	32	15
Full time	68	52	4	63	43	32
Part time	15	11	1	19	15	4
Union	78	65	8	54	66	27
Nonunion	53	40	2	53	33	25
Establishment characteristics:						
Goods-producing[4]	69	55	4	42	49	29
Construction	40	28	1	22	23	10
Manufacturing	80	65	5	48	59	34
Service-producing	51	39	3	57	32	24
Transportation and public utilities	73	55	5	67	49	35
Wholesale trade	70	53	6	66	43	39
Retail trade	31	20	1	34	20	7
Finance, insurance, and real estate	75	49	2	83	49	55
Services	52	42	3	62	31	25
1-99 workers	43	30	1	47	25	17
1-49 workers	37	25	1	44	20	15
50-99 workers	63	49	3	57	43	23
100 workers or more	70	57	5	60	49	36
100-499 workers	65	54	3	54	44	29
500-999 workers	77	60	2	61	58	36
1,000-2,499 workers	71	57	9	67	45	37
2,500 workers or more	84	66	14	73	60	60
Regions:[5]						
Northeast	58	46	2	58	66	29
South	55	41	3	54	27	24
Midwest	57	46	5	46	38	29
West	52	38	2	55	24	20

[1] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[2] Employees are classified as working either a full-time or part-time schedule based on the definition used by each establishment. Union workers are those whose wages are determined through collective bargaining.

[3] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[4] Includes data for mining not shown separately.

[5] The regional coverage is as follows: Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; South—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; and West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

NOTE: Where applicable, dash indicates no employees in this category.

Table 3. Percent of workers with access to leave and family-related benefits by selected worker and establishment characteristics, private industry, National Compensation Survey,[1] 1999

Characteristics	Paid vacations	Paid holidays	Employer assistance for child care				Adoption assistance	Long-term care insurance	Flexible work place
			Total[2]	Employer provided funds	On-site child care	Off-site child care			
Total	79	75	6	4	3	2	6	6	3
Worker characteristics:[3]									
Professional, technical, and related employees[4]	88	89	12	7	6	3	11	11	7
Clerical and sales employees[4]	80	77	5	3	2	1	6	7	3
Blue-collar and service employees[4]	75	69	4	3	2	1	3	3	1
Full time	90	87	6	4	3	2	6	7	4
Part time	43	36	6	4	3	1	2	4	1
Union	86	82	5	4	1	1	7	3	2
Nonunion	78	75	6	4	3	2	5	6	3
Establishment characteristics:									
Goods-producing[5]	84	84	2	2	1	1	7	5	3
Construction	63	68	1	1	1	1	1	1	1
Manufacturing	91	90	3	2	1	2	10	7	4
Service-producing	77	73	7	4	3	2	5	6	3
Transportation and public utilities	92	86	1	1	(6)	(6)	9	12	1
Wholesale trade	89	91	4	3	-	1	5	6	8
Retail trade	64	50	4	3	(6)	(6)	2	5	1
Finance, insurance, and real estate	86	91	9	6	4	3	12	15	10
Services	79	77	10	5	6	2	5	4	2
1-99 workers	73	70	3	2	1	(6)	1	2	2
1-49 workers	70	66	2	1	1	(6)	1	2	2
50-99 workers	84	81	3	3	1	1	3	2	3
100 workers or more	86	82	10	6	4	3	11	10	4
100-499 workers	83	80	7	5	2	2	5	8	4
500-999 workers	89	87	8	4	2	3	12	8	2
1,000-2,499 workers	89	87	18	11	7	7	17	15	6
2,500 workers or more	88	82	14	7	10	2	22	19	6
Regions:[7]									
Northeast	79	79	6	3	4	2	8	8	3
South	78	75	5	4	3	1	5	6	2
Midwest	80	76	7	4	2	2	5	6	4
West	79	72	5	4	1	(6)	4	4	3

[1] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[2] The total may be less than the sum of individual items because some employees were receiving more than one type of employer assistance for child care.

[3] Employees are classified as working either a full-time or part-time schedule based on the definition used by each establishment. Union workers are those whose wages are determined through collective bargaining.

[4] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[5] Includes data for mining not shown separately.

[6] Less than 0.5 percent.

[7] The regional coverage is as follows: Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; South—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; and West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

NOTE: Where applicable, dash indicates no employees in this category.

Table 4. Percent of workers with access to non-wage cash payments, subsidized commuting, and cafeteria benefits by selected worker and establishment characteristics, private industry, National Compensation Survey,[1] 1999

Characteristics	Non-wage cash payments			Subsidized commuting	Section 125 cafeteria benefits[2]			
	Nonproduction bonus	Supplemental unemployment benefits	Severance pay		Total	Flexible benefit plans	Reimbursement plans	Premium conversion plans
Total	42	2	22	4	28	7	15	6
Worker characteristics:[3]								
Professional, technical, and related employees[4]	48	1	36	9	43	13	24	5
Clerical and sales employees[4]	42	1	24	4	30	6	16	8
Blue-collar and service employees[4]	39	3	14	3	20	6	10	4
Full time	46	2	26	5	32	9	17	6
Part time	28	([5])	8	3	14	3	8	3
Union	29	10	28	7	24	7	12	4
Nonunion	43	1	21	4	28	7	15	6
Establishment characteristics:								
Goods-producing[6]	47	5	25	4	26	9	12	5
Construction	50	2	6	2	8	1	4	3
Manufacturing	46	6	31	4	32	12	15	5
Service-producing	40	1	21	5	28	7	15	6
Transportation and public utilities	53	([5])	29	11	36	14	13	8
Wholesale trade	43	3	24	1	30	9	16	5
Retail trade	29	1	13	1	18	2	11	5
Finance, insurance, and real estate	55	2	44	5	51	15	23	12
Services	41	([5])	19	6	28	6	17	5
1-99 workers	46	1	13	3	18	3	10	6
1-49 workers	46	([5])	10	1	13	2	6	5
50-99 workers	48	2	26	8	33	3	23	7
100 workers or more	37	3	31	6	39	13	21	6
100-499 workers	33	1	24	3	31	7	19	5
500-999 workers	45	3	33	6	39	13	19	8
1,000-2,499 workers	32	3	33	13	49	16	25	8
2,500 workers or more	48	10	53	12	61	33	24	4
Regions:[7]								
Northeast	42	1	23	4	29	9	15	4
South	40	1	21	3	28	7	12	10
Midwest	44	4	21	4	28	9	15	4
West	43	1	23	9	26	5	18	2

[1] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[2] Includes all types of plans under Internal Revenue Code Section 125. Flexible benefits plans include reimbursement account features.

[3] Employees are classified as working either a full-time or part-time schedule based on the definition used by each establishment. Union workers are those whose wages are determined through collective bargaining.

[4] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[5] Less than 0.5 percent.

[6] Includes data for mining not shown separately.

[7] The regional coverage is as follows: Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; South—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; and West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

Table 5. Percent of workers with access to education assistance, travel insurance, and health promotion benefits by selected worker and establishment characteristics, private industry, National Compensation Survey,[1] 1999

Characteristics	Education assistance		Travel accident insurance	Health promotion benefits		
	Work related	Non-work related		Wellness programs	Employee assistance programs	Fitness centers
Total	41	10	20	17	33	9
Worker characteristics:[2]						
Professional, technical, and related employees[3]	63	14	35	29	48	18
Clerical and sales employees[3]	39	10	22	15	32	8
Blue-collar and service employees[3]	34	9	12	13	27	6
Full time	47	12	22	19	36	10
Part time	21	6	11	11	21	5
Union	46	15	17	24	46	7
Nonunion	41	10	20	16	31	9
Establishment characteristics:						
Goods-producing[4]	46	14	21	19	36	8
Construction	27	4	8	4	8	4
Manufacturing	53	18	26	25	45	9
Service-producing	40	9	19	16	32	9
Transportation and public utilities	43	16	25	28	48	9
Wholesale trade	45	6	21	18	31	6
Retail trade	16	6	13	4	20	2
Finance, insurance, and real estate	69	14	38	30	48	13
Services	47	9	18	18	33	13
1-99 workers	29	5	10	6	14	4
1-49 workers	25	4	8	4	9	2
50-99 workers	43	8	19	11	32	9
100 workers or more	55	17	31	30	54	15
100-499 workers	47	12	25	19	42	8
500-999 workers	58	13	29	34	59	19
1,000-2,499 workers	67	23	33	39	69	21
2,500 workers or more	70	30	52	54	77	30
Regions:[5]						
Northeast	44	11	22	19	37	10
South	40	12	21	14	33	8
Midwest	39	9	18	18	33	8
West	42	9	18	17	29	10

[1] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[2] Employees are classified as working either a full-time or part-time schedule based on the definition used by each establishment. Union workers are those whose wages are determined through collective bargaining.

[3] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[4] Includes data for mining not shown separately.

[5] The regional coverage is as follows: Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; South—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; and West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

NOTE: Where applicable, dash indicates no employees in this category.

Table 6. Medical care benefits: Percent of participants required to contribute and average employee contribution, private industry, National Compensation Survey,[1] 1999

Characteristics	Single Coverage			Family Coverage		
	Employee contributions not required	Employee contributions required	Average[2] flat monthly contribution in dollars	Employee contributions not required	Employee contributions required	Average[2] flat monthly contribution in dollars
Total	33	67	$48.30	19	81	$169.84
Worker characteristics:[3]						
Professional, technical, and related employees[4]	31	69	45.34	16	84	163.31
Clerical and sales employees[4]	29	71	47.70	15	85	174.18
Blue-collar and service employees[4]	37	63	50.67	24	76	171.12
Union	52	48	48.65	46	54	129.08
Nonunion	30	70	48.27	14	86	173.77
Full time	34	66	47.81	19	81	168.68
Part time	22	78	57.49	15	85	192.65
Establishment characteristics:						
Goods-producing[5]	39	61	42.08	25	75	149.73
Construction	65	35	56.66	49	51	256.00
Manufacturing	32	68	40.49	18	82	132.84
Service-producing	30	70	50.92	17	83	178.94
Transportation and public utilities	30	70	57.87	19	81	179.49
Wholesale trade	36	64	40.95	27	73	161.91
Retail trade	22	78	59.32	17	83	212.70
Finance, insurance, and real estate	28	72	45.41	16	84	164.62
Services	33	67	50.54	14	86	175.28
1-99 workers	42	58	52.52	24	76	191.93
1-49 workers	46	54	55.63	27	73	199.78
50-99 workers	33	67	47.01	16	84	176.51
100 workers or more	25	75	45.16	15	85	150.74
100-499 workers	29	71	45.08	16	84	162.25
500-999 workers	22	78	40.98	13	87	127.93
1,000-2,499 workers	22	78	46.48	13	87	150.58
2,500 workers or more	19	81	49.35	17	83	136.90
Regions:[6]						
Northeast	27	73	54.18	20	80	178.99
South	30	70	51.85	12	88	187.46
Midwest	32	68	42.33	23	77	144.99
West	44	56	42.50	26	74	156.11

[1] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[2] The average is presented for all covered workers and excludes workers without the plan provision. Averages are for plans stating a flat monthly cost.

[3] Employees are classified as working either a full-time or part-time schedule based on the definition used by each establishment. Union workers are those whose wages are determined through collective bargaining.

[4] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[5] Includes data for mining, not shown separately.

[6] The regional coverage is as follows: Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; South—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; and West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

Table 7. Medical care benefits: Percent of participants, by amount and type of employee contribution for individual coverage, private industry, National Compensation Survey,[1] 1999

Type and amount of contribution	All employees	Professional, technical, and related employees[2]	Clerical and sales employees[2]	Blue-collar and service employees[2]
Number with contributory coverage (in thousands)	38,060	10,495	11,333	16,233
	Percent			
Total with contributory coverage	100	100	100	100
Flat monthly amount	66	66	67	65
Less than $5.00	1	([3])	1	1
$5.00 - 9.99	2	1	1	2
$10.00 - 14.99	4	4	5	4
$15.00 - 19.99	4	4	3	6
$20.00 - 29.99	10	13	10	9
$30.00 - 39.99	10	10	11	10
$40.00 - 49.99	10	12	11	8
$50.00 - 59.99	7	6	9	7
$60.00 - 69.99	6	7	7	5
$70.00 - 79.99	4	2	3	4
$80.00 - 89.99	2	1	3	1
$90.00 - 99.99	2	1	2	2
$100.00 - 124.99	2	2	1	2
$125.00 or greater	3	2	2	4
Dollar amount unspecified	([3])	-	([3])	([3])
Composite rate[4]	3	2	2	4
Varies[5]	10	9	12	9
Other	([3])	([3])	([3])	([3])
Flexible benefits[6]	8	11	5	7
Percent of earnings	1	([3])	1	1
Exists, but unknown	13	11	13	14

[1] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[2] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[3] Less than 0.5 percent.

[4] A composite rate is a set contribution covering more than one benefit area, for example, health care and life insurance. Cost data for individual plans cannot be determined.

[5] Based on worker attributes. For example, employee contributions may vary based on earnings, length of service, or age.

[6] Amount varies by options selected under a "cafeteria plan" or employer-sponsored reimbursement account.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

Table 8. Medical care benefits: Percent of participants, by amount and type of employee contribution for family coverage,[1] private industry, National Compensation Survey,[2] 1999

Type and amount of contribution	All employees	Professional, technical, and related employees[3]	Clerical and sales employees[3]	Blue-collar and service employees[3]
Number (in thousands) with contributory coverage	45,994	12,882	13,489	19,623
	Percent			
Total with contributory coverage	100	100	100	100
Flat monthly amount	69	68	69	69
Less than $20.00	1	1	1	2
$20.00 - 29.99	1	1	1	1
$30.00 - 39.99	2	2	2	2
$40.00 - 49.99	3	2	3	3
$50.00 - 59.99	2	2	2	2
$60.00 - 69.99	2	2	3	2
$70.00 - 79.99	3	6	2	2
$80.00 - 89.99	3	4	2	3
$90.00 - 99.99	3	3	4	3
$100.00 - 124.99	8	7	8	9
$125.00 - 149.99	8	10	8	7
$150.00 - 174.99	6	6	5	6
$175.00 - 199.99	5	6	5	4
$200.00 - 224.99	4	4	4	3
$225.00 - 249.99	4	3	4	4
$250.00 - 274.99	4	2	3	4
$275.00 - 299.99	1	1	2	1
$300.00 or greater	10	8	10	11
Composite rate[4]	3	4	2	3
Varies[5]	10	9	13	9
Other	([6])	([6])	([6])	([6])
Flexible benefits[7]	7	10	5	6
Percent of earnings	1	([6])	1	1
Exists, but unknown	10	9	10	11

[1] If the amount of contribution varied by either size or composition of family, the rate for an employee with a spouse and one child was used. For a small percentage of employees, the employee contributes the same amount for single and family coverage.

[2] The survey covers all 50 States. Collection was conducted between March 1999 and April 2000. The average reference period was September 1999.

[3] A classification system including about 480 individual occupations is used to cover all workers in the civilian economy. See the Technical Note for more information.

[4] A composite rate is a set contribution covering more than one benefit area, for example, health care and life insurance. Cost data for individual plans cannot be determined.

[5] Based on worker attributes. For example, employee contributions may vary based on earnings, length of service, or age.

[6] Less than 0.5 percent.

[7] Amount varies by options selected under a "cafeteria plan" or employer-sponsored reimbursement account.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

TECHNICAL NOTE

The data in this release are from the National Compensation Survey (NCS), conducted by the Bureau of Labor Statistics, U.S. Department of Labor. The statistics in this release represent a transitional step in the integration of the Employee Benefits Survey data into the NCS. For the first time, data on private establishments of all sizes have been produced simultaneously, and they are presented by characteristics not previously included, such as more detailed worker and establishment characteristics. This release, however, is limited to 1999 data on incidence of benefits and on employee contributions to medical care. The next release will contain 2000 data, with details of benefit plan provisions, as well as incidence information.

Previously, surveys of different sectors of the economy were conducted in alternating years; medium and large private establishments were studied during odd years, and small private establishments and State and local governments during even years. Separate publications were produced for each sample. In the future, all types of establishments will be surveyed each year, and the data will be produced by numerous characteristics, including establishment size and sector of the economy.

Definitions of survey terms

Incidence refers to different methods of computing the number or percentage of employees that receive a benefit plan or specific benefit feature. Access to a benefit is determined on an occupational basis within an establishment; either all employees or no employees in an occupation in an

establishment have the benefit available to them. The benefits published in tables 3, 4 and 5 refer to employee access. Participation refers to the proportion of employees covered by a benefit. There will be cases where employees with access to a plan will not participate. For example, some employees may decline to participate in a health insurance plan if there is an employee cost involved. The benefits published in tables 1 and 2 refer to employee participation. For a listing of selected benefit definitions, see *Glossary of Compensation Terms,* U.S. Department of Labor, Bureau of Labor Statistics, August 1998, Report 923, or on the Internet at http://www.bls.gov/ncs/ocs/sp/ncb10062.pdf.

Section 125 of the Internal Revenue Code governs three types of plans: flexible benefit plans, reimbursement accounts, and premium conversion plans. Under flexible benefit plans, employees are able to create a benefits package from among several options. Reimbursement accounts, or flexible spending accounts, are funded by employee pretax contributions to pay for health care or dependent care benefits. Premium conversion plans allow medical plan participants to pay the required plan premium with pretax dollars.

Survey scope

The 1999 NCS benefits incidence survey obtained data from 3,168 private industry establishments, representing over 107 million workers; of this number, nearly 83 million were full-time workers and the remainder--slightly over 24 million--were part-time workers. The NCS uses the establishment's definition of full-and part-time status. For purposes of this survey, an establishment is an economic unit that produces

goods or services, a central administrative office, or an auxiliary unit providing support services to a company. For private industries, the establishment is usually at a single physical location.

Sample design and data collection

The sample for this survey was selected using a three-stage design. The first stage involved the selection of areas. The NCS sample consists of 154 metropolitan areas and nonmetropolitan areas that represent the Nation's 326 metropolitan statistical areas (as defined by the Office of Management and Budget) and the remaining portions of the 50 States. Metropolitan areas are either Metropolitan Statistical Areas (MSAs) or Consolidated Metropolitan Statistical Areas (CMSAs), as defined by the Office of Management and Budget, in 1994. Nonmetropolitan areas are counties that do not fit the metropolitan area definition.

In the second stage, the sample of establishments was drawn by first stratifying the sampling frame by industry and establishment size. The number of sample establishments allocated to each stratum is approximately proportional to the stratum employment. Each sampled establishment was selected within a stratum with a probability proportional to its employment. Use of this technique means that the larger an establishment's employment, the greater its chance of selection. Weights were applied to each establishment when the data were tabulated so that each establishment represents similar units (in terms of industry and employment size) in the economy that were not selected for collection.

The third stage of sample selection was a probability sample of occupations within a sampled establishment. Identification of the occupations for which data were to be collected was a four-step process:

1. Probability-proportional-to-size selection of establishment jobs.

2. Classification of jobs into occupations based on the Census of Population system.

3. Characterization of jobs as full-time versus part-time, union versus nonunion, and time versus incentive.

4. Determination of the level of work of each job.

For more detailed information on occupational selection and classification under the National Compensation Survey, see *National Compensation Survey, Occupational Wages in the United States, 1999,* U.S. Department of Labor, Bureau of Labor Statistics, July 2001, Bulletin 2539. For an online version, see:
http://www.bls.gov/ncs/ocs/sp/ncb10343.pdf.

Additional information about the National Compensation Survey may be obtained by calling (202) 691-6199. You may also write to the Bureau of Labor Statistics at: Division of Compensation Data Analysis and Planning, 2 Massachusetts Ave., NE, Room 4175, Washington, DC 20212-0001, or send e-mail to *OCLTINFO@bls.gov.*

The data contained in this summary are available on the Bureau's Internet site: ***http://www.bls.gov/ncs***. The

Benefits Public Data Query System for selective online access to benefits data is now available on the same page.

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APPENDIX F

U.S. Department of Labor
Bureau of Labor Statistics Data

Employee Benefits Survey

Original Data Value

Series Id:	EBULIFEINC0000ML
Title:	Incidence Of Life Insurance
Type:	Medium and Large Private Sector

Year	**Annual**
1988	92
1989	94
1991	94
1993	91
1995	87
1997	87

Bureau of Labor Statistics Data

U.S. Department of Labor
Bureau of Labor Statistics Data

Employee Benefits Survey

Original Data Value

Series Id:	EBULIFEINC0000SM
Title:	Incidence Of Life Insurance
Type:	Small Private Sector Establishments

Year	**Annual**
1990	64
1992	64
1994	61
1996	64

U.S. Department of Labor
Bureau of Labor Statistics Data

Employee Benefits Survey

Original Data Value

Series Id:	EBUMEDINC00000ML
Title:	Incidence Of Medical Care Benefits
Type:	Medium and Large Private Sector

Year	**Annual**
1988	90
1989	92
1991	83
1993	82
1995	77
1997	76

Original Data Value

Series Id:	EBUMEDINC00000SM
Title:	Incidence Of Medical Care Benefits
Type:	Small Private Sector Establishments

Year	**Annual**
1990	69
1992	71
1994	66
1996	64

U.S. Department of Labor
Bureau of Labor Statistics Data

Employee Benefits Survey

Original Data Value

Series Id:	EBUSELFINS0000ML
Title:	Percent Of Employees With Medical Care In Self-insured Plans
Type:	Medium and Large Private Sector

Year	**Annual**
1988	34
1989	36
1991	39
1993	46
1995	47
1997	47

Original Data Value

Series Id:	EBUSELFINS0000SM
Title:	Percent Of Employees With Medical Care In Self-insured Plans
Type:	Small Private Sector Establishments

Year	**Annual**
1990	28
1992	32
1996	23

Supreme Court, U.S.
FILED
MAY 28 2002

No. 01-1586

IN THE

Supreme Court of the United States

LYN EVERHART,

Petitioner,

v.

ALLAMERICA FINANCIAL LIFE INSURANCE COMPANY, doing business as STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT CERTIORARI

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WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20001

ISSUE PRESENTED

Does section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* ("ERISA"), permit suits for plan benefits against plan insurers based solely on their status as "insurers"?

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Supreme Court Rule 10 6

IN THE

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No. 01-1586

LYN EVERHART,

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v.

ALLAMERICA FINANCIAL LIFE INSURANCE COMPANY, doing business as STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT CERTIORARI

STATEMENT OF THE CASE

This petition arises from Petitioner Lyn Everhart's ("Everhart's") attempt to recover additional ERISA benefits under the employee benefit plan (the "Plan") covering her deceased husband, Charles Everhart. The Plan was sponsored and administered by Mr. Everhart's employer, Credence Systems Corporation ("Credence"), and insured by Defendant/Respondent Allmerica.[1] Following her husband's

[1] The Respondent has been misnamed in this lawsuit. Petitioner sued "Allmerica Financial Life Insurance Company d/b/a State Mutual Life

death, Allmerica paid petitioner the full death benefits purchased from Allmerica based upon the representations made by Mr. Everhart. Petitioner settled with the Plan and its administrator for an additional $230,000. Petitioner then sued the plan's insurer, Allmerica, for more benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

On cross-motions for summary judgment, Allmerica and Everhart asked the district court to determine, among other things, whether Everhart had standing to sue Allmerica for ERISA benefits under the Plan. Based on the Ninth Circuit's ruling in *Gelardi v. Pertec Computer Corporation*, 761 F.2d 1323 (9th Cir. 1985), the district court granted summary judgment in Allmerica's favor on the ground that Everhart's claim for plan benefits could only have been brought against the Plan as an entity, with which she has already settled.

The Ninth Circuit affirmed judgment in Allmerica's favor on the ground that Everhart may not sue an insurer (who is not a plan administrator) for ERISA benefits. The Court of Appeal noted that it need not address the split among Courts of Appeal regarding the propriety of suits for benefits against plan administrators because Everhart had admitted that Allmerica was not the Plan's administrator and, in any event, had released all claims against the Plan's "administrators."

STATEMENT OF FACTS

The facts in this case are straightforward and undisputed. Indeed, they are substantially drawn from a Stipulation of the Parties as to Material Facts.

Assurance Company of America." Respondent's name is actually First Allmerica Financial Life Insurance Company. Throughout this brief, Respondent is referred to as "Allmerica."

A. The Policy, The Plan, And Charles Everhart

Allmerica issued to Credence's employee benefit plan a group life insurance policy (the "Policy"). The Plan was administered by Credence.[2] The parties have admitted that the Plan and the Policy are governed by ERISA.

Charles Everhart was a Credence employee who participated in the Plan. The terms of the Policy entitled Mr. Everhart's designated beneficiary to a death benefit comprised of twice his annual earnings. According to the representations contained in the Policy's application, Mr. Everhart's annual earnings were $84,800. On December 5, 1994, Mr. Everhart died.

Shortly after Mr. Everhart's death, a dispute arose with respect to the identity of Mr. Everhart's designated beneficiary for the purposes of distributing his death benefits. Once that dispute was resolved, Allmerica promptly paid Everhart $170,000 plus interest as the "benefits payable under the Policy." Pursuant to the terms of the Policy, this amount represented twice Mr. Everhart's annual earnings, as stated in the Policy's application, rounded to the nearest thousand.

B. Petitioner's Settlement With The Plan's Administrator And Release Of All ERISA Claims Against The Plan And Its "Administrators"

Following Mr. Everhart's death, a dispute also arose as to whether Credence owed Mr. Everhart unpaid benefits and compensation at the time of his death. That dispute was

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[2] As petitioner conceded in her Reply Brief filed in the Ninth Circuit: "The summary plan description specifically identifies the plan administrator as 'Credence Systems Corporation,' not Allmerica." (Respondent's Appendix B, p. 21a.) A copy of Everhart's Reply Brief is reproduced in Respondent's Appendix B.

resolved through settlement. In return for a $230,000 payment from Credence, Everhart released all ERISA claims against Credence's "*employer sponsored employee benefit and welfare benefit plans*, trustees and *administrators* of such employee benefit plans, employees, contractors and assigns." (Emphasis added).[3] Specifically, the Release provided as follows:

> Everhart understands and agrees that in further consideration of the foregoing she is waiving any rights she may have had, now has, or in the future may have to pursue any and all remedies available to her under any employment-related causes of action, including without limitation, claims for breach of contract, breach of the covenant of good faith and fair dealing, fraud, claims under the Employee Retirement Income Security Act of 1974, claims for employee benefits, and any other laws and regulations relating to her husband's employment or compensation.

(*Id.*)

C. Everhart's Dispute With Allmerica

After receiving the $202,829.79 benefits payment from Allmerica and releasing all ERISA claims against the Plan and its administrators, Everhart sought further payment from Allmerica.

Everhart informed Allmerica that, although Mr. Everhart represented his annual earnings as $84,800, her investigation had revealed that Mr. Everhart's earnings had been misrepresented and that she believed his actual annual earnings were $240,000. Accordingly, Everhart demanded payment of $310,000, the difference between $170,000 and

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[3] A copy of the Release is reproduced in Respondent's Appendix A.

the $480,000 to which Everhart claimed she was entitled. Allmerica declined further payment on the ground that it had paid all benefits due under the terms of the Policy. In response, Everhart filed the instant suit against Allmerica for recovery of ERISA benefits.

As the district court and the Court of Appeals held, Everhart has no avenue for further recovery against Allmerica. Given that Everhart has settled with and released all claims for additional benefits against the Plan and its administrators, Allmerica was entitled to summary judgment. This holding is consistent with the plain text of ERISA and a national body of case law.

ARGUMENT

Contrary to the fundamental assumption underlying Everhart's petition, no Circuit Court of Appeal has ever held that a suit for plan benefits is proper against a plan's insurer based solely on its status as an insurer. Rather, as the Ninth Circuit's majority opinion correctly observed, the only "split" in the case law concerns whether ERISA permits suits for benefits against insurers in their capacity as plan *administrators*. Because Credence was the Plan administrator and petitioner has released all claims against the Plan's administrators, this case presents no occasion to resolve any purported "conflict" among the Circuits concerning the propriety of ERISA suits against plan administrators. Petitioner's request for an advisory opinion on this issue should be denied

In any event, the district court and the Court of Appeals properly concluded that petitioner possesses no viable claim for plan benefits against Allmerica. Neither the text of ERISA, nor existing case law, permits a suit for benefits against an insurer who is not a plan administrator. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Since Everhart

has settled with and released the plan and its administrator from all claims for additional benefits, she is precluded from further recovery. Moreover, petitioner's proposed distinction between insured and "self-funded" plans is not supported by the text of ERISA and would frustrate the legislative goals of providing clear and expeditious remedies under ERISA by encouraging duplicative suits for the recovery of ERISA benefits.

For the following reasons, respondent respectfully requests that the Court deny this Petition for Writ of Certiorari.

I. EVERHART'S REQUEST FOR AN ADVISORY OPINION SHOULD BE REJECTED

The Supreme Court Rules are clear that a Petition for Writ of Certiorari "is not a matter of right, but of judicial discretion." Supreme Court Rule 10. In that spirit, "[a] petition for writ of certiorari will be granted only for compelling reasons." *Id.* The Supreme Court Rules set out specific circumstances in which review may be appropriate. In an attempt to satisfy the requirements for review by certiorari, Everhart's petition is premised entirely upon an imaginary "three way split" among the Circuit Courts of Appeal concerning the universe of proper defendants in suits for plan benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

Petitioner, however, has identified no case *holding* that a suit for plan benefits is proper against a plan's insurer based solely on its status as the plan's insurer. The only "split" among the Courts of Appeal concerns the propriety of a suit for benefits against a plan "administrator," as opposed to the plan as an entity. Because Everhart did not sue the plan or its administrator, however, this distinction has no bearing on the outcome of this case. The petition, therefore, seeks an advisory opinion and should be denied.

A. The Only "Split" Among The Circuits Concerns The Propriety Of Benefits Suits Against Plan Administrators, An Issue Not Presented In This Case

In *Gelardi v. Pertec Computer Corporation*, 761 F.2d 1323, 1324 (9th Cir. 1985), the Ninth Circuit held that "ERISA permits suits to recover benefits only against the Plan as an entity." *See also Gibson v. Prudential Life Ins. Co.*, 915 F.2d 414, 415 (9th Cir. 1990); *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1287 (9th Cir. 1990), *cert. denied*, 498 U.S. 1087, 111 S.Ct. 964 (1991). The Second and Seventh Circuits have followed *Gelardi*. *See Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir. 1993) ("ERISA permits suits to recover benefits only against the Plan as an entity." (*quoting Gelardi*)); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996) ("The appropriate defendant for a denial of benefits claim would be the Plan . . ."); *see also Ross v. Rail Car America Group Disability Income Plan*, 285 F.3d 735, 740 (8th Cir. 2002) ("The employee benefit plan itself is ordinarily liable for benefits payable under the terms of the plan and is thus the primary defendant in a section 502(a)(1)(B) action." (citation omitted)).

As the Ninth Circuit observed in its majority opinion below, the Sixth and Eleventh Circuits have rejected *Gelardi* and permitted suits for plan benefits under § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), against plan "administrators" (which generally tend to be employers). *See Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir.), *cert. denied*, 488 U.S. 825, 109 S.Ct. 76 (1988) ("Unless an employer is shown to control administration of a plan, it is not a proper party defendant in an action concerning benefits"); *Layes v. Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998) (holding that employer was not proper party defendant in ERISA action for benefits

because insurer was at all relevant times the sole administrator of plan); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) ("The proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan.").

Under either of these two lines of authority, however, petitioner has no claim against Allmerica. Because petitioner did not sue the Plan, the first line authority bars her suit. Moreover, because petitioner did not sue the Plan's "administrator" and, indeed, has released all ERISA claims against the Plan's "administrators," the second line of authority bars her suit, as well.

B. No Court of Appeal Has *Held* That ERISA Permits Benefits Suits Against Plan Insurers Based *Solely* On Their Status As "Insurers"

Petitioner bases her petition for certiorari on her contention that a third line of cases has interpreted ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), as permitting suits for benefits against plan insurers based solely on their status as insurers. Petitioner is wrong.

The primary case petitioner cites in support of her contention that the Courts of Appeal are "split" regarding the propriety of suits for ERISA benefits against plan insurers is *Curcio v. John Hancock Mutual Life Insurance Company*, 33 F.3d 226 (3d Cir. 1994). This case simply does not support her contention. In *Curcio*, the insurer obtained summary judgment on the ground that the terms of the insurance policy it had issued the plan did not cover the benefits sought by the plaintiff. *Curcio* did not address the propriety of a suit for ERISA benefits against the insurer.

Petitioner's reliance on *Ward v. Management Analysis Company Employee Disability Benefit Plan*, 135 F.3d 1276

(9th Cir. 1998), *rev'd in part*, 526 U.S. 358, 119 S.Ct. 1380 (1999) and *Cisneros v. UNUM Life Ins. Co. of Am.*, 134 F.3d 939 (9th Cir. 1998), is equally unavailing. As the majority opinion below explained:

> [N]either decision addresses the issue nor makes clear what UNUM's role was under each of the plans at issue. *See, e.g., Ward*, 135 F.3d. at 1288 ("Whether MAC acted as fiduciary and as agent of UNUM in administering the MAC Plan's long-term disability policy, particularly in receiving and forwarding claims for benefits, cannot be decided as a matter of law on the existing record.") (emphasis added and footnote omitted). To the extent this circuit's decisions in this area may be talking past each other, we feel bound to follow those that are explicit in their holdings.

(Petitioner's Appendix B, p. 15a-16a.)

Indeed, as indicated in *Ward*, it is not uncommon for a plan insurer to appear on behalf of a benefit plan in a suit seeking ERISA benefits in order to protect the plan's interests, even though the insurer has not itself been sued. 135 F.3d at 1279.[4]

Finally, petitioner's reliance on *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475 (9th Cir. 1997), *aff'd sub nom, Humana, Inc., v. Forsyth*, 525 U.S. 299, 119 S.Ct. 710 (1999), is also misplaced. As the Ninth Circuit here observed, the insurer in *Forsyth* "functioned as the plan administrator." (Petitioner's Appendix B, p. 15a.)

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[4] "Plaintiff filed his complaint against the MAC Plan to recover his claimed benefits under ERISA . . . UNUM appeared as a defendant and filed an answer on behalf of itself and the MAC Plan. . . ." *Ward*, 135 F.3d at 1279.

Petitioner has identified no Court of Appeal opinion that has *held* ERISA permits a suit for benefits against an insurer who did not function as plan administrator. Instead, petitioner has pieced together four opinions that involved claims for benefits against plan insurers, but which did not address the propriety of those suits under ERISA. As this Court has declared on numerous occasions, a case may not be cited for a principle not stated therein. *See Landgraf v. USI Film Products*, 511 U.S. 244, 265, 114 S.Ct. 1483 (1994) ("the 'maxim not to be disregarded that general expressions, in every opinion, are to be taken in connection with the case in which those expressions are used.'" (quotation omitted)); *R.A.V. v. St. Paul*, 505 U.S. 377, 386, n. 5, 112 S.Ct. 2538 (1992) (it is "contrary to all traditions of our jurisprudence to consider the law on this point conclusively resolved by broad language in cases where the issue was not presented or even envisioned"); *United States v. Stanley*, 483 U.S. 669, 680, 107 S.Ct. 3054 (1987) ("no holding can be broader than the facts before the court").

* * *

In short, petitioner's purported "three-way split" among the Circuits amounts to nothing more than a red herring designed to obtain Supreme Court review of a nonexistent issue. Again, petitioner cites no case that *held* a suit for ERISA benefits against a plan insurer is proper. Instead, petitioner merely relies on the fact that a few courts have *permitted* (but not discussed the propriety of) such suits against plan insurers. As the Court of Appeals observed here, such cases do not support petitioner's position because they did not fully (or even briefly) discuss the issue of whether an insurer is a proper defendant in a suit to recover ERISA benefits.

Thus, the Court should decline petitioner's invitation to resolve the issue of whether ERISA permits suits for benefits against plan "administrators"—the only arguable split among

the Courts of Appeal. Because petitioner did not sue the Plan "administrator" and has released all claims against the Plan's "administrators," resolution of the issue would have no bearing on the outcome of this case. While respondent agrees that public policy encourages the delineation of clear remedies under ERISA, that public policy is not served by issuing advisory opinions. *See Flast v. Cohen*, 392 U.S. 83, 97, 88 S.Ct. 1942 (1968) ("the Article III prohibition against advisory opinions reflects the complementary constitutional considerations expressed by the justiciability doctrine"); *U.S. v. Fruehauf*, 365 U.S. 146, 157, 81 S.Ct. 547 (1961) ("such advance expressions of legal judgment upon issues which remain unfocused because they are not pressed before the Court with that clear concreteness provided when a question emerges precisely framed . . . we have consistently refused to give"). Because the petition presents no basis for Supreme Court review, it should be denied.

II. ERISA DOES NOT PERMIT SUITS FOR BENEFITS AGAINST INSURERS WHO ARE NOT PLAN ADMINISTRATORS

In addition to the fact that petitioner seeks an advisory opinion, review should be denied because judgment in Allmerica's favor was proper (under either line of authority discussed above), given the unique factual circumstances of this case. ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), does not permit suits for plan benefits against insurers who are not plan administrators.

A. Neither The Text Of ERISA, Nor Case Law, Permits Suits For Benefits Against Plan Insurers Based Solely On Their Status As "Insurers"

Section 502 of ERISA provides, in relevant part:

> (a) . . .
>
> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> * * *
>
> (B) to recover benefits due to him . . .
>
> * * *
>
> (d) . . .
>
> * * *
>
> (2) . . . only against the plan as an entity . . . .

29 U.S.C. § 1132. *See also Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 833, n. 7, 108 S.Ct. 2182 (1988).

In *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985), the Ninth Circuit interpreted this plain language to hold that "ERISA permits suits to recover benefits *only against the Plan as an entity*." (Emphasis added.) This principle has been affirmed by the Ninth Circuit and other Courts of Appeal in a legion of cases. *See Spain v. Aetna Life Ins. Co.*, 13 F.3d 310, 311-12 (9th Cir. 1993); *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1287 (9th Cir. 1990), *cert. denied*,

498 U.S. 1087, 111 S.Ct. 964 (1991); *Gibson v. Prudential Ins. Co.*, 915 F.2d '414, 417 (9th Cir. 1990); *Riordan v. Commonwealth Edison Co.*, 128 F. 3d 549, 551 (7th Cir. 1997); *Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir. 1993) (quoting *Gelardi*, 761 F. 2d at 1324).[5]

As explained in the preceding section, while there are cases in which courts have permitted recovery of ERISA benefits from insurers, such cases involve situations in which the insurer is acting as the plan's administrator. *See, e.g., Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1087 (1999), *cert. denied*, 528 U.S. 964, 120 S.Ct. 398 (1999); *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475 (9th Cir. 1997); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997). Here, Credence was the Plan's administrator, not Allmerica. (Respondent's Appendix B, p. 21a.) Moreover, even if Allmerica is somehow deemed to be a "plan administrator," petitioner's claims are precluded because she has released all claims against the Plan's "administrators." (Respondent's Appendix A.)

In a desperate attempt to identify a statutory basis for her contention that ERISA permits suits for plan benefits against insurers, petitioner suggests ERISA Section 502(d)(2) should

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[5] District courts nationwide have followed *Gelardi*, as well. *See Adkins v. Unum Provident Corp.*, 191 F. Supp. 2d 956, 958 (M.D. Tenn. 2002); *Hupp v. Experian Corp.*, 108 F. Supp. 2d 1008, 1013 (N.D. Ill. 2000); *Holland v. Bank of America*, 673 F. Supp. 1511, 1517 (S.D. Cal. 1987); *Roeder v. Chemrex Inc.*, 863 F. Supp. 817, 828 (D. Wis. 1994); *Auto Club Ins. Ass'n v. Safeco Life Ins. Co.*, 833 F. Supp. 637, 643 (W.D. Mich. 1993); *Murphy v. Wal-Mart Assocs. Group Health Plan*, 928 F.Supp. 700, 710 (E.D. Tex. 1996); *Crawford v. Exxon Corp.*, 851 F.Supp. 242, 244 (M.D. La. 1994); *Holloway v. HECI Exploration Co. Employee's Profit Sharing Plan*, 76 B.R. 563, 570 (N.D. Tex. 1987). So too have state courts. *Cohen v. Equitable Life Assurance Society*, 196 Cal. App. 3d 669, 672 (1987); *Lambert v. Pacific Mut. Life Ins. Co.*, 211 Cal. App. 3d 456, 461, *review denied*, (1989).

be construed as permitting suits under 502(a)(1)(B) against entities other than the Plan. In fact, Section 502(d)(2) says nothing of the kind. To the contrary, the language of the sections 502(a)(1)(B) and 502(d), read together, clearly and unambiguously provides that the plan is the only entity against whom claims for benefits under the plan may be brought:

> Any money judgment under this subchapter against an employee benefit plan shall be enforceable *only against the plan as an entity and shall not be enforceable against any other person* unless liability against such person is established in his individual capacity under this subchapter.

§ 502(d)(2), 29 U.S.C. § 1132(d)(2) (emphasis added).

On its face, this language deals with the enforceability of a judgment obtained against the plan under Section 502(a)(1)(b). Here, petitioner has released all ERISA claims against the Plan. (Respondent's Appendix B.) Hence, there necessarily can be no "money judgment" against the Plan or any other person to be enforced under Section 502(d)(2).

Moreover, even to the extent that Section 502(d)(2) was somehow construed to permit a claim under Section 502(a)(1)(B) against someone other than the plan, it is clear from the above language that there must be established some independent basis for liability against such individual. Examples of such an independent basis would include a claim against a plan administrator under Section 502(a)(1)(A) or a fiduciary under Section 502(a)(2).[6] Here Everhart does not,

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[6] Allmerica notes that Everhart cannot state a claim against Allmerica under ERISA § 502(a)(2) for breach of fiduciary duty pursuant to ERISA § 409(a), 29 U.S.C. § 1109(a), which authorizes a beneficiary to bring an action against a fiduciary for breach of fiduciary duty on behalf of the

and could not, assert any such theory of individual liability against Allmerica.[7] Rather she seeks only plan benefits under Section 501(a)(1)(B), but seeks them from an entity that is not the Plan or its administrator.

Moreover, petitioner's reliance on *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 120 S.Ct. 2180 (2000), is misplaced. In *Harris*, the Supreme Court held that ERISA Section 502(a)(3), which allows a court to award equitable relief in the case of a breach of fiduciary duty, allows an action to be brought not only against the breaching fiduciary, but also against a Party in Interest with knowledge of the breach. *Harris* in no way involved the provision under which Everhart seeks damages against Allmerica, ERISA Section 502(a)(1)(B), which authorizes suits for Plan benefits. In fact, *Harris* reaffirmed that "ERISA's comprehensive and reticulated scheme warrants a cautious approach to inferring remedies not expressly authorized by the text." *Id.* at 247 (quotation marks omitted). Moreover, the Court in *Harris* relied on the language of § 1132(l) as explicitly authorizing suits for breach of fiduciary duty against a fiduciary or "other person." *Id.* at 247-48 (quotation marks and citations omitted). ERISA contains no similar express authorization to reach third parties exists for § 1132(a)(1)(B).

Plan, *but not for the beneficiary's personal damages. Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140, 105 S.Ct. 3085 (1985); *Horan v. Kaiser Steel Retirement Plan*, 947 F.2d 1412, 1418 (9th Cir. 1991). Here, Everhart is not seeking to recover damages on behalf of the Plan; she is seeking a personal recovery in the form of additional benefits. Accordingly, she cannot state a claim against Allmerica for breach of fiduciary duty pursuant to ERISA.

[7] Everhart's suggestion that 29 U.S.C. Section 1002(1) provides a basis for independent liability against Allmerica is wholly without merit. Section 1002(1) merely *defines* the term "employee welfare benefit plan."

Thus, the plain language of ERISA does not permit suits for plan benefits to be maintained against plan insurers based solely on their status as insurers. Petitioner cites no provision of ERISA (or passage from its legislative history) supporting a distinction between remedies available to beneficiaries of insured and self-funded plans. A national body of case law confirms that suits for ERISA benefits may not be maintained against plan insurers that are not plan administrators. Because petitioner has admitted that Credence was the Plan's administrator and, in any event, has released all claims for ERISA benefits against the Plan's "administrators," there is no basis for her suit against Allmerica.

B. Permitting Suits Against Plan Insurers For ERISA Benefits Would Frustrate the Legislative Intent Underlying ERISA.

Petitioner asks this Court to create a new remedy under ERISA available to participants and beneficiaries of an insured benefit plan (as opposed to "self-funded" plan). Petitioner's distinction between self-funded benefit plans and insured plans not only has no basis whatsoever in the language of ERISA, it is contrary to the extensive case law interpreting ERISA discussed in the previous section. ERISA nowhere distinguishes between the remedies available against insured and self-funded plans.[8] Moreover, ERISA nowhere authorizes a suit to recover benefits by a plan participant or beneficiary against a plan's insurer.

Had Congress intended to distinguish between ERISA remedies available to beneficiaries of insured and self-funded benefit plans, Congress would have so indicated in the text of

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[8] Such distinction has been recognized for purposes of preemption by ERISA. ERISA § 514(b)(1), 29 U.S.C. § 1444(b)(1). This is not an issue in this case.

the statute. As this Court has cautioned concerning the enactment of ERISA:

> Congress did not intend to authorize other remedies that it simply forgot to incorporate generally. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute.' . . . We are reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA . . . Where a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it.

Russell, 473 U.S. at 146-47 (internal citations and quotation marks omitted). *See also Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 647 (7th Cir. 1993) (Although Congress expected courts to create a body of federal common law under ERISA, this is done only when "ERISA itself does not itself expressly address the issue before the court." (citation and internal quotation marks omitted)). To adopt petitioner's distinction between insured and "self-funded" employee benefit plans for purposes of establishing liability under ERISA would require this Court (literally) to write words into the text of ERISA.

In addition to lacking statutory support, petitioner's proposed construction of ERISA would contravene the legislature's intent. One of the public policies underlying the enactment of ERISA is the provision of clear and final remedies to participants and beneficiaries. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53-55, 107 S.Ct. 1549 (1987); *Russell*, 473 U.S. 134 at 146-47. Another is avoiding burdens on the court system through, for example, duplicative suits such as this one. *See, e.g., Menhorn v. Firestone Tire & Rubber So.*, 738 F.2d 1496, 1500, n. 2 (9th Cir. 1984) (explaining that Congress authorized suits for benefits under

section 1132(a)(1)(B) to be brought in both state and federal court to "mitigate to some degree the burden on the federal courts resulting from ERISA").

Under petitioner's theory, a plan participant or beneficiary would be free to pursue two separate actions to recover plan benefits: one against the plan and a second against the plan's insurer. Such a scheme would frustrate the legislative goals of providing clear and expeditious remedies under ERISA.

Congress has provided participants and beneficiaries with a clear remedy through which to obtain unpaid plan benefits: a suit against the plan. *See* 29 U.S.C. § 1132(a)(1)(B). There is simply no reason to carve out a new (and duplicative) remedy for participants and beneficiaries of an insured (as opposed to self-funded) plan. Indeed, Allmerica had no contractual relationship with Everhart here and was not acting as the Plan administrator. Everhart presents *no* reason—and certainly *no* compelling reason—why this Court should tamper with the remedies enumerated in the plain language of the statute.

CONCLUSION

As both the district court and the Court of Appeals held, petitioner lacks standing to sue Allmerica for ERISA benefits, regardless of whether ERISA permits suits for benefits against plan administrators. Allmerica is neither the Plan, nor the Plan's administrator. Moreover, *no legal authority* supports petitioner's assertion that ERISA benefits are recoverable against plan insurers who are not plan administrators. Accordingly, respondent respectfully requests that the Court deny this Petition for Writ of Certiorari.

Respectfully submitted,

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APPENDICES

APPENDIX A

RELEASE

THIS RELEASE of all claims against CREDENCE SYSTEMS CORPORATION, its past, present and future partners, parents, subsidiaries, related entities, predecessors, successors, directors, officers, agents, employer sponsored employee benefit and welfare benefit plans, trustees and administrators of such employee benefit plans, employees, contractors and assigns (hereinafter collectively called "Credence"), is made by LYN EVERHART (hereinafter "Everhart").

WITNESSETH:

WHEREAS. Everhart is the widow of Charles Everhart who was for a period of time an employee of Credence until he passed away on December 6, 1994; and

WHEREAS, a dispute has arisen over alleged compensation and benefits owed from Credence to the estate of Mr. Everhart;

WHEREAS, the parties wish to resolve this dispute in a way which will preserve the good will which exists between them and to settle all disputes and avoid Litigation;

NOW, THEREFORE, for and in consideration of the payment by Credence to Everhart of a sum, of two hundred thirty thousand dollars ($230,000) and for other good and sufficient consideration, Everhart, fully and forever releases and discharges Credence from, and covenants not to sue or otherwise institute any legal or administrative proceedings against Credence with respect to any matter arising out of or relating to her spouse's employment with Credence.

A. foregoing she is waiving any rights she may have had, now has, or in the future may have to pursue any and all remedies available to her under any employment-related causes of action, including without limitation, claims for breach of contract, breach of the covenant of good faith and fair dealing, fraud, claims under the Employee Retirement Income Security Act of 1974, claims for employee benefits, and any other laws and regulations relating to her husband's employment or compensation.

B. This RELEASE shall be deemed to have been entered into in the State of California and shall be construed and interpreted in accordance with the laws of that state.

C. In addition, and in further consideration of the foregoing, Everhart hereby expressly waives any and all rights and benefits conferred upon her by the provisions of Section 1542 of the Civil Code of the State of California, which states as follows:

> A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor.

D. Everhart acknowledges and agrees that no promises or representations were made which do not appear written herein and that this RELEASE contains the entire agreement of the parties as to the subject matter thereof.

E. Everhart hereby acknowledges that she has read and understands the foregoing RELEASE and that she signs it voluntarily and without coercion. Everhart further acknowledges that she has consulted with an attorney of her own choosing concerning the waivers contained in this RELEASE, and that the waivers she has made herein are

knowing, conscious and with fall appreciation that she is forever foreclosed from pursuing any of the rights so waived.

Executed this 21st day of March, 1997.

/s/ Lyn Everhart
LYN EVERHART
Law Offices of Charles J. Wisch

Charles J. Wisch
Attorney for Lyn Everhart

APPENDIX B

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT

Docket No. 99-17094

LYN EVERHART,
Appellant and Plaintiff,

vs.

ALLMERICA FINANCIAL LIFE INSURANCE COMPANY,
doing business as STATE MUTUAL LIFE ASSURANCE
COMPANY OF AMERICA,
Appellee and Defendant.

Appeal from Judgment of the United States District Court
for the Northern District of California
(No. CV-99-00733 VRW)

APPELLANT'S REPLY BRIEF

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INTRODUCTION

Appellee Allmerica's numerous arguments are designed to distract the court from Everhart's central contention: that there is a difference in who can properly be sued for an ERISA benefits claim depending upon whether the employee benefit plan is self-funded or insured. In the case of self-funded plan, only the plan can be sued for benefits because it is the only entity obligated to pay those promised benefits. By contrast, where the plan has purchased insurance to provide benefits, the insurer has undertaken a contractual obligation that permits plan beneficiaries to sue either the insurer or the plan for the promise benefits.

That difference is aptly illustrated by the two opinions of this circuit in *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323 (9th Cir. 1985), and *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 19970 *aff'd sub nom. Humana, Inc. v. Forsyth*, 119 S.Ct. 710 (1999). *Gelardi* and *Forsyth* are consistent with one another and with ERISA. Gelardi held that, in the case of a self-funded plan, only the plan could be sued because it was the only entity owing benefits to the beneficiares.[1] In *Forsyth*, by contrast, the plan exercised it express right under ERISA, 29 U.S.C. § 1002(1), to purchase insurance to provide the promised benefits. Thus, both the plan and the insurer owed a contractual duty to the beneficiaries to pay those benefits, subjecting both to liability.

There is no statutory or public policy justification for granting the insurer immunity from suit where it refused to pay benefits. The common law is directly to the contrary,

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[1] By definition, a "self-funded plan" is funded by the employer, not an insurance policy. While an insurance company may administer the plan, only the employer pays into the plan whatever funds are subsequently disbursed to pay the promised benefits. See *Lee v. Burkhart*, 991 F.2d 1004, 1006 (2d Cir. 1993).

universally permitting beneficiaries of insurance policies to sue the insurer for refusal to pay promised benefits. Nothing in either the language or statutory history of ERISA suggest that Congress intended to immunize insurers from suits for benefits where the plan has exercised its right under ERISA to by such insurance.

Allmerica has also raised two new issues, unrelated to its status as a proper party and not relied upon by the district court, to justify the district court's grant of summary judgment. First, Allmerica asserts that it was released from liability when Everhart settled with and released Credence, although the release provides nothing of the sort. Second, Allmerica asserts that it was entitled to an absolute defense on the basis of fraud, although the policy's incontestability clause bars such a defense and the facts are clearly contested. Neither of Allmerica's additional arguments justified summary judgment. The judgment should be reversed.

ARGUMENT

A. Everhart Properly Sued Allmerica for Its Refusal to Pay Benefits under the Life Insurance Policy

Allmerica strives unsuccessfully to distinguish *Forsyth's* holding allowing employee benefit plan beneficiaries to sue the plan insurer for recovery of benefits under 29 U.S.C. § 1132(a)(1)(B). (Allmerica Brief, 13-23.)

Ignoring that *Gelardi* involved a self-funded plan, Allmerica asserts that insured plans are governed by that case's statement that "ERISA permits suits to recover benefits only against the Plan as an entity . . ." *Gelardi*, 761 F.2d at 1324. In order to create a straw man, Allmerica mischaracterize Everhart's position as asserting that *Forsyth* sub silentio overruled *Gelardi*. To the contrary, Everhart contends that both cases are perfectly consistent when viewed in their

respective factual contexts. Allmerica completely ignores that *Gelardi* dealt with a self-funded plan that paid the promised benefits, while in *Forsyth*, the plan had purchased insurance, allowing the beneficiaries to sue the insurance company for violating its contractual obligation to pay those promised benefits.

Post-*Forsyth*, although not directly addressing this issue, the Ninth Circuit has repeatedly permitted ERISA benefits claims against plans' insurers. For example, *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998), reversed a summary judgment that had been granted on grounds unrelated to the question of proper defendants. The court permitted the beneficiary to pursue her claim against the insurer for ERISA benefits, although the plan was not joined as a party.

A similar result was reached in *Ward v. Management Analysis Company Employee Disability Plan*, 135 F.3d 1276 (9th Cir. 1998), aff'd in part and rev'd in part on other grounds sub nom. *Unum Life Ins. Co. v. Ward*, __ U.S. 119 S.Ct. 1380 (1999). The employer had created an employee benefit plan, and the plan funded the benefits with insurance purchased from UNUM. 135 F.3d at 1278; see 119 S.Ct. at 1386 n. 2 ("this case does not involve a self-insured plan"). The district court dismissed the plaintiffs benefits claim. Impliedly recognizing that the beneficiary had a right to pursue that claim against the insurer, both the Ninth Circuit and the Supreme Court reversed and reinstated the benefits claim without any suggestion whatsoever that the insurer was not a proper defendant. See 119 S.Ct. at 1391 ("Ward sued under § 502(a)(1)(B) [29 U.S.C. § 1132(a)(1)(B)] 'to recover benefits due . . . under the terms of his plan.'")

Allmerica, attempts to distinguish *Forsyth* on the grounds that the defendant insurer had "stipulated" to the assertion of an ERISA benefits claim against it. Allmerica ignores the

established rule that the federal courts not only must refuse to resolve matters outside their subject matter jurisdiction, but also have an obligation sua sponte to raise that jurisdictional issue regardless of the parties' actions. *American Fire & Casualty Co. v. Finn*, 341 U.S. 6, 17-18 and n. 17 at 18 (1951); *Hajek v. Burlington Northern Railroad Co.*, __ F.3d __, 1999 WL 569363 (9th Cir. 1999). If ERISA does not provide a beneficiary the remedy of a benefits claim against the plan's insurer, the defendant in *Forsyth* could not have stipulated to such subject matter jurisdiction. In fact, if Allmerica's reading of ERISA and the *Gelardi* holding were correct, the panels in *Forsyth*, *Cisneros*, and *Ward* would have been obligated to order dismissal of the benefits claims against the insurers for lack of subject matter jurisdiction. That all three Ninth Circuit panels and, in *Ward*, the Supreme Court, specifically allowed the cases to proceed demonstrates that beneficiaries can assert ERISA benefits claims against their plans' insurers.

Virtually all of the case law Allmerica cites fails to support its assertion that a plan beneficiary can sue only the plan, and not an insurer, for benefits. Most of the cases did not involve any issue of insurance at all because, like *Gelardi*, the plan

was self-insured.[2] In most of the rest, no benefits claim was asserted against any plan insurer.[3]

Allmerica does cite four cases—three district court opinions, and one from the California Court of Appeal—in which the courts held that a beneficiary could not assert a benefits claim against a plan's insurer. None of those cases correctly considers the distinction between a self-funded plan and an insured plan. Moreover, three of the cases predated *Forsyth*, and the fourth failed to discuss *Forsyth* at all in the context of the benefits claim:

> 1. In *Lambert v. Pacific Mutual Life Ins. Co.*, 211 Cal.App.3d 456, 463 (1989), the California Court of Appeal recited that *Gelardi* had held "ERISA permits suits to recover benefits only against the plan as an entity, and not the employer or insurer . . ." That holding was clearly erroneous, as there was no insurance claim at issue in *Gelardi* because the plan had been self-funded.

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[2] *Gibson v. Prudential Life Ins. Co.*, 9 15 F.2d 414, 415 (9th Cir. 1990) [insurance company was a—claims processing agent, not an insurer of the benefits]; *Spain v. Aetna Life Ins. Co.*, 13 F.3d 310, 311, 312 (9th Cir. 1993) [insurance company was plan administrator, not an insurer of the benefits]; *Lee v. Burkhart*, supra, 991 F.2d 1004, 1006 (2d Cir. 1993) (self-funded plan]; *Auto Club Ins. Assn. v. Safeco Life Ins. Co.*, 833 F.Supp. 637, 638, 640 (W.D. Mich. 1993) [self-funded employee benefits plan; "the insurance contract at issue in this case was not purchased by the Plan"]; *Ghorbani v. Pacific Gas & Electric Co.*, 1998 WL 184312, *1 (N.D. Cal. 1998) [self-funded plan].

[3] *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279, 1282 (9th Cir. 1990); *Holland v. Bank of America*, 673 F.Supp. 1511, 1518 (S.D. Cal. 1987) [beneficiary erroneously sued employer; insurer not a party]; *Riordan v. Commonwealth Edison Co.*, 128 F.3d 549 (7th Cir. 1997); *Cohen v. Equitable Life Assurance Society of the United States*, 196 Cal.App.3d 669, 672 (1987) (plan's insurer erroneously cross-complained against employer rather than plan for recovery of allegedly overpaid benefits].

2. In *Mann v. New England Mutual Life Ins. Co.*, 1991 WL 631954, *2 (N.D. Cal. 1991), an unreported opinion, the district cited *Gelardi* and *Lambert* as holding that ERISA did not permit suits "against an employer or insurer." The court failed to recognize that *Gelardi* had not considered any insurance issue because it involved a self-funded plan, and that *Lambert* had misstated the ruling in *Gelardi*.

3. *Roeder v. Chemrex Inc.*, 863 F.Supp. 817 (E.D. Wisc. 1994) held that, under the undisputed facts of the case, the plaintiff was ineligible for benefits under the insurance policy purchased by the employee benefit plan. 863 F.Supp. at 827. In dictum, the court added that the plaintiff's failure to join the plan justified dismissing his complaint for benefits. Besides being dictum, the court's ruling disregarded the final clause of 29 U.S.C. § 1132(d), providing for liability for benefits against persons other than the plan where that liability is "established in his individual capacity under this subchapter."

4. The only post-*Forsyth* case cited by Allmerica is the unreported opinion in *Yacobucci v. Sun Life Assurance Co.*, 1999 WL 300647 (N.D. Cal. 1999).[4] In *Yacobucci*, as here, the district court did not consider that the cases it relied upon all involved self-funded plans, rather than instances where the plans had purchased insurance to provide the promised benefits. Moreover, although it referenced *Forsyth* on another issue, the court did not consider the *Forsyth* ruling's impact upon a beneficiary's right to assert a claim against the plan insurer.

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[4] That opinion was rendered by the same court as the present case.

Thus, none of the cases cited by Allmerica supports any ruling that a beneficiary seeking recovery of benefits can only sue the plan, and not the insurer, where the plan is not self-funded but has provided the promised benefits through insurance.

By artful editing of 29 U.S.C. § 1132, Allmerica also tries to argue that ERISA expressly limits suits for recovery of benefits to claims against a plan. (See Allmerica Brief, p. 13.) To the contrary, § 1132 does not impose any such limitation upon suits for benefits.

29 U.S.C. § 1132(a)(1)(B) specifically allows beneficiaries such as Everhart to sue for recovery of benefits due under the terms of the plan. The section does not, however, identify who can be sued.

29 U.S.C. § 1132(d) makes plans liable for suits for benefits, but does not restrict such suits to plans alone:

> "(1) An employee benefit plan may sue or be sued under this subchapter as an entity. . .
>
> "(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter."

ERISA thus provides that a plan can sue and be sued, and is liable for judgments rendered against it. ERISA also provides that a judgment against the plan can only be enforced against the plan, thus protecting the employer or the plan administrator from personal liability for the plan's obligations. That is the meaning of this circuit's ruling in *Gelardi*. However, § 1132(d) in no way restricts benefits

claims against any other parties who might have a legal obligation to pay those benefits, such as an insurance company that has contracted to pay benefits under the terms of the plan.[5]

In adopting ERISA, Congress explicitly authorized employee benefits plans to purchase insurance to provide the promised benefits. 29 U.S.C. § 1002(l). Consequently, under the scheme established by Congress, employee benefits plans have the option of either funding promised benefits themselves, or purchasing insurance policies to shift to the insurer funding of those benefits. Of course, the plan incurs the cost of any insurance policy it purchases. However, the insurer contracts with the plan, for the intended benefit of all beneficiaries, to provide the promised benefits.

There certainly is no reason to believe that, in adopting ERISA, and particularly § 1002(l), Congress was unaware that the common law universally applied throughout the United States provides that beneficiaries of insurance policies have the right to sue insurers who deny them the promised benefits of an insurance policy. See Restatement (2d) Contracts, § 302(l)(b) and comm. c, illustration 4, and § 304; 17B C.J.S. § 619. Moreover, there is no provision in ERISA that Congress, having authorized employee benefit plans to purchase insurance, intended to abrogate that common law

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[5] Allmerica attempts to imply that the Supreme Court held in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 833 n. 7 (1988), that § 1132 expressly limits benefits claims to plans only. (See Allmerica Brief, p. 13.) The *Mackey* case does not so hold or imply. On the contrary, the Supreme Court merely confirmed that ERISA provides in § 1132 that the plan can "sue or be sued." 486 U.S. at 832-833. The Court did not consider whether an insurer that has contracted with a plan in accordance with 29 U.S.C. § 1002(l) was somehow immunized from suits for benefits.

right of beneficiaries.[6] On the contrary, in the absence of explicit statutory language immunizing insurers from such liability, *Forsyth* correctly held that ERISA allowed beneficiaries to sue the insurance company for benefits under § 1132(a)(1)(B), and that holding applies equally here. Everhart, as an intended beneficiary of the insurance contract between Credence and Allmerica, had the right to sue Allmerica when it denied her the full benefits promised by that contract.

Allmerica's further argument that allowing such an action would somehow encourage "duplicative lawsuits" is nonsense. Under the usual joinder rules, a beneficiary would be entitled to join both the plan and the insurer in a suit for recovery of the promised benefits. Fed.R.Civ.P. 20. Similarly, a plan or insurer sued for benefits, and claiming that the other is liable for those benefits, would be entitled to bring the other into the case through a third party complaint. Fed.R.Civ.P. 14. Finally, a beneficiary who failed to join both obligors would risk the bar of collateral estoppel if it tried to assert successive lawsuits. Fed.R.Civ.P. 14. Finally, a beneficiary who failed to join both obligors would risk the bar of collateral estoppel if it tried to assert successive lawsuits.

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[6] Contrary to Allmerica's red herring argument (Allmerica Brief, 21-22), Everhart does not contend that Congress, in enacting ERISA, "forgot" to grant the remedy of an action for benefits against plan insurers. Congress well knew that the common law allows beneficiaries to sue insurers for policy benefits. By authorizing employee benefit plans to purchase insurance to provide benefits, and jurisdiction to award benefits in both the state and federal courts, Congress intended that common law principle to be applied by the courts. See *Security Life Ins. Co. of America v. Meyling*, 146 F.3d 1184,1191 (9th Cir. 1998); *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1499, 1500 n. 2 (9th Cir. 1984); *Equitable Life Assurance Society v. Crysler*, 66 F.3d 944, 948-949 (8th Cir. 1995).

Forsyth and *Gelardi* are simply two sides of the same rule: A party that assumes responsibility to pay benefits under an employee benefit plan—either a plan that is self-funded or an insurance company that sells the plan insurance to fund those benefits—is liable to the beneficiary for those benefits under 29 U.S.C. § 1132(a)(1)(B). The district court's summary judgment dismissing Everhart's claim against Allmerica for plan benefits should be reversed.

B. Everhart Has Never Released Her Claim Against Allmerica

Without the benefit of any authority whatsoever, Allmerica asserts that Everhart has released Allmerica by having entered into a separate release with Credence. (Allmerica Brief, 24-26.) That argument is completely misconceived.

On March 21, 1997, Everhart entered into a release with Credence relating to "a dispute . . . over alleged compensation and benefits owed from Credence to the estate of Mr. Everhart . . ." (ER 7, ¶ 9; ER 44.) "Credence" was defined in the release to include Credence and "its past, present and future partners, parents, subsidiaries, related entities, predecessors, successors, directors, officers, agents, employer sponsored employee benefit and welfare plans, trustees and administrators of such employee benefit plans, employees, contractors and assigns." (ER 44.)

Allmerica asserts that neither Everhart nor Charles had any contractual relationship with Allmerica, and therefore any claim would have to arise out of some theory that Allmerica was either a "related entity" or "contractor" of Credence. Allmerica further asserts that, because Everhart released Credence's related entities and contractors, she released Allmerica. These assertions are erroneous in three regards.

First, Everhart does not need a direct contractual relationship with Allmerica to sue it for denial of benefits. As Everhart was an intended beneficiary of the insurance policy, the common law followed in every state provides her the right to sue Allmerica for denial of the promised benefits. See Restatement (2d) Contracts, § 302(l)(b) and comm. c, illustration 4, and § 304; 17B C.J.S. § 619.

Second, Allmerica is not a "related entity" of Credence as that term is defined in law. The term "related entities" refers to entities that share ownership, officers, or directors, or may be parent and subsidiary corporations. See, e.g. *Sea Harvest Corp. v. Riviera Land Co.*, 868 F.2d 1077, 1078 (9th Cir. 1989); *Likins-Foster Honolulu Corp. v. Comm'r Internal Revenue Service*, 840 F.2d 642, 646 (9th Cir. 1987). The record is devoid of any evidence that Allmerica and Credence had common ownership or directors, or were parent and subsidiary.

Third, Allmerica is not a "contractor" of Credence. The release between Everhart and Credence specifically recited that it is to be construed in accordance with California law. (ER 45, ¶ B].) The term "contractor" "is commonly reserved to designate one who, for a fixed price, undertakes to procure the performance of works or services on a large scale, or the furnishing of goods in large quantities . . ." Black's Law Dictionary (Westlaw On-Line Ed.). Moreover, the term "contractor" is statutorily defined to mean "builder." Cal. Bus. & Prof. C. § 7026. "Insurance," by contrast, is a contract undertaking to indemnify another against loss, damage, or liability from a contingent or unknown event. Cal. Insur. C. § 22. Allmerica, as an insurer, is defined by law as one "who undertakes to indemnify another by insurance." Cal. Insur. C. § 23. By no stretch of the imagination could Allmerica be a "contractor" of Credence under the terms of the release.

Allmerica asserts an alternative argument that, because the release applied to "administrators of such employee benefit plans" (see ER 44), it was released under that language. Allmerica erroneously relies upon a general dictionary definition of the term "administrator," disregarding the fact that the terms "administrator" and "plan" used in the release are specifically defined by ERISA. Those definitions do not include Allmerica.

A "plan" is defined as the plan established by the employer. 29 U.S.C. § 1002(l). The statute states that a plan provides benefits, and may do so "through the purchase of insurance." *Id.* Such insurance is not, as a matter of law, the plan itself. Moreover, the summary plan description provided by Credence to its employees in this case identifies the plan as "Credence Systems Corporation," not Allmerica. (ER 37, ¶ 1.)

Similarly, the term "administrator" is a term of art defined by ERISA to mean "the person specifically so designated by the terms of the instrument under which the plan is operated." 29 U.S.C. § 1002(16)(A)(i). The summary plan description specifically identifies the plan administrator as "Credence Systems Corporation," not Allmerica. (ER 37, ¶ 6.)

Allmerica was not released by the March 21, 1997 agreement between Everhart and Credence.

C. Allmerica Cannot Rescind or Modify the Amount of Benefits Payable to Everhart by Asserting "Fraud"

Allmerica asserts that it was entitled to escape its liability to pay the entire death benefit promised in the policy—two times Charles' annual earnings, i.e. $480,000—due to alleged fraud, but instead that it could pay only the lesser amount of $170,000. (Allmerica Brief, 26-34.) Allmerica's argument ignores the policy language (1) specifically waiving fraud, (2)

promising specified benefits of "two times basic annual earnings," and (3) providing that Credence, as the "Policyholder," not Everhart as a beneficiary or Charles as an employee, was liable to reimburse Allmerica for any benefits paid based upon erroneous information.

First, the policy contains an express incontestability provision waiving any alleged fraud:

> "No statement made by a covered person will be used to contest the validity of any life coverage after it has been in force for two years during the lifetime of that person." (ER 21, Section 6.0.)

The parties stipulated that Charles became enrolled under the policy on October 5, 1992, more than two years prior to his death on December 5, 1994. (ER 7, ¶¶ 5, 8].) Thus, under the contract's incontestability provision, Allmerica could not rely upon any allegedly fraudulent statement of earnings to rescind Charles' full death benefit of two times his annual earnings.

Second, in an effort to avoid the incontestability provision, Allmerica attempts to mischaracterize its position as "enforcing" the policy. This mischaracterization is accomplished by Allmerica's ignoring the policy language specifically promising "[t]wo times basic annual earnings." (ER 15.) Instead, Allmerica argues that it is simply providing two times the amount of Charles' earnings as set forth in a false earnings disclosure. Allmerica is actually attempting to rescind the policy and substitute a new provision to the effect that the benefit will be two times Charles' declaration, not his basic annual earnings.

Through its argument that Charles' supposed misrepresentation was "material" to its premium calculations, Allmerica has unwittingly admitted that it is not attempting to

enforce the policy, but to rescind and rewrite it. (Allmerica Brief, 30-34.) The cases cited by Allmerica demonstrate that a material misrepresentation is relevant only insofar as the misrepresentation justifies rescission of the policy. *Security Life Ins. Co. of America v. Meyling*, supra, 146 F.3d 1184, and particularly 1191-1193. Either the policy is enforced according to its express terms or it is rescinded; Allmerica cannot rewrite it. Through the incontestability provision, however, Allmerica contractually surrendered the right to rescind for false statements. Therefore, the policy must be enforced in accordance with its promise of "two times basic annual earnings." [7]

Moreover, even if Allmerica could rescind, there exists a factual dispute whether the allegedly false statement materially affected the premium. The test for whether a

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[7] Allmerica's cases do not support its to be enforcing the insurance policy. In *New York Life Ins. Co. v. Hollender*, 38 Cal.2d 73 (1951), the policy expressly allowed adjustment of the benefits if the age of the insured were misstated. *Id.* at 76. The insured misstated his age, and the insurer merely enforced the age adjustment provision. *Id.* at 78-83. There is no similar express provision here allowing Allmerica to adjust the amount of life insurance to something other than two times Charles' basic annual earnings.

In *Turner v. Safeco Life Insurance Co.*, 17 F.3d 141 (6th Cir. 1994), the plaintiff's deceased husband never became entitled to a group policy's death benefit because he did not satisfy the policy's employment eligibility condition. *Id.* at 145. The incontestability provision was irrelevant to his ineligibility. *Id.* at 145-146. Charles was an employee of Credence and, thus, eligible for life insurance of two times basic annual earnings.

In *Baseheart v. Life Insurance Co. of North America*, 960 F.Supp. 1210 (W.D. Ky. 1997), the employee was ineligible to purchase an additional benefit beyond the basic benefit provided by the policy. *Id.* at 1212. The policy here provides a basic benefit of "two times basic annual earnings." The issue here is calculating that basic benefit, not whether Charles qualified for some "additional benefit."

misrepresentation is "material" is whether Allmerica would either have refused to issue the insurance had it known the truth or would have charged a materially different premium. *Security Life Insur. Co. v. Meyling*, *supra*, 146 F.3d at 1192, 1193 ("[P]revarication alone is legally insufficient to actuate rescission. If the contrary were true, a materiality requirement would have no meaning."); *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904, 916 (1973).

Allmerica charged a premium of $.21 per $1,000 of life coverage under the policy, resulting in a gross premium to Credence for the group life coverage of $134,878 per year. (ER 191.) The difference in the premium paid by Credence between a benefit for Charles' beneficiaries of $170,000 and $480,000, would have been $781, approximately one-half of one percent of the total premium paid for the group policy. (ER 108-109, ¶ 6.) The trier of fact could reasonably have determined such a tiny difference in premium to be de minimis and, accordingly, immaterial in the face of a $135,000 premium for the group policy.[8]

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[8] Allmerica submitted a declaration from Nicholas P. Titone, which stated that the difference in Charles' annual earnings "would materially affect Allmerica's calculation of premiums charged for the policy." (ER 79, ¶ 9.) Mr. Titone's statement was an inadmissible conclusion invading the trier of fact's discretion to decide what is and what is not material, to which Everhart objected under Fed.R.Civ.P. 56(e). (ER 101, fn. 5.) Moreover, the trier of fact was not required to believe such "'post mortem' testimony" of the insurer's state of mind. *Thompson*, 9 Cal.3d at 916.

Given Mr. Titone's statement, Allmerica should have been subjected to discovery concerning its underwriting practices, premium calculations, internal standards for determining "materiality" of economic information used for group life policies, and the like, none of which had been accomplished at the early stage of the proceedings that Allmerica's summary judgment motion was brought. This objection was raised to the district court (ER 101, fn. 5), and would have compelled denial of

Third, Allmerica disregards that the policy specifies a remedy for any allegedly overpaid benefits. The policy provides that "[t]he monthly premium due on each premium due date will be the sum of the amounts for each of the benefits provided in the policy." (ER 200.) Allmerica correctly asserts that it was Credence, the policyholder, that was responsible for reporting the correct amount of earnings of each employee, including Charles. (Allmerica Brief, 28-29; see ER 198.) The policy provides:

> "If the Company [Allmerica] pays claims that it would not have paid had the information been correctly provided, the Policyholder [Credence] shall reimburse the Company for any and all claims paid in error." (ER 198.)

Thus, Allmerica has a mandatory, self-executing remedy in the policy against Credence for either additional premium due for the amount of coverage actually provided or for any purported overpayment of benefits due to Credence's failure properly to report Charles' earnings. With such "an automatic compensation mechanism" provided in the policy, Allmerica would not be allowed to rescind the coverage and benefits payable to Everhart regardless of any misrepresentation by Charles. *Security Life Insur. Co. v. Meyling*, supra, 146 F.3d at 1192. Finally, Allmerica also asserts that its denial of the full amount of insurance benefits claimed by Everhart must be reviewed under an "abuse of discretion" standard. (Allmerica Brief, 29-30.) The "abuse of discretion" standard applies to discretion exercised by a plan administrator. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *Taft v. Equitable Life Assur. Society*, 9 F.3d 1469, 1471 (9th Cir. 1994). Allmerica is not the plan administrator here, and conceded as much in the district

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Allmerica's motion, so far as it relied upon Mr. Titone's declaration, until that discovery had been taken. Fed.R.Civ.P. 56(f).

court. (ER 70, n. 4.) Credence was the plan administrator. There is no legal basis for Allmerica to claim that it is entitled to the benefit of any deference by the courts to its coverage decisions, or that those decisions must be reviewed under an abuse of discretion standard.

To the extent that the court might believe that Allmerica is entitled to such an abuse of discretion review, the record demonstrates a triable factual dispute over whether Allmerica did abuse its discretion in refusing to pay Everhart the full amount of benefits under the life insurance policy. Discretion is abused where the insurer "'construe[s] provisions of the plan in a way that clearly conflicts with the plain language of the plan.'" *Taft v. Equitable Life Assur. Society*, supra, 9 F.3d at 1472. The plain language of the plan provides a death benefit of "[t]wo times basic annual earnings." (ER 15.) "Basic annual earnings" is expressly defined as "annual earnings" including "bonuses and commissions." (ER 20.) Allmerica seeks not to enforce the plain language of the plan, but to pay a different amount than the promised benefit. Under *Taft*, Allmerica's action is a clear abuse of discretion.[9]

Allmerica was not entitled to summary judgment on grounds of fraud.

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[9] At the very least, Everhart should have had the opportunity to conduct discovery on Allmerica's exercise of "discretion" before the district court could consider any dispositive motion on whether that discretion was abused.

CONCLUSION

The district court erroneously granted Allmerica summary judgment on grounds that Allmerica, as the Credence employee benefit plan's insurer, was not a proper party defendant on a benefits claim under ERISA, 29 U.S.C. § 1132(a)(1)(B). Neither of the other grounds asserted by Allmerica in its brief would justify summary judgment. The judgment should be reversed.

Dated: March 8, 2000

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to FRAP 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached reply brief is proportionately spaced, has a typeface of 14 points, and contains 4973 words by word processor count, not including the cover, tables of contents or authorities, certificate of service, or this certificate of compliance.

Dated: March 8, 2000

LAW OFFICES OF CHARLES J. WISCH

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PROOF OF SERVICE

I am employed in the City and County of San Francisco, that I am over the age of eighteen (18) years, and am not a party to the within cause, and that my business address is 655 Montgomery Street, 12th Floor, San Francisco, California 94111.

I am readily familiar with the business' practice for the collection and processing of correspondence for mailing with the United States Postal Service; and that the correspondence would be deposited with the United States Postal Service that same day in the ordinary course of business.

On March 8, 2000, at San Francisco, California, I served the within:

APPELLANT'S REPLY BRIEF

by placing [a] true copy[ies] in a sealed envelope, which envelope was then placed for collection and mailing on said date following ordinary business practices, addressed as follows:

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 8, 2000

Cathryn Waters
Legal Assistant

Supreme Court, U.S.
FILED
JUN 5 2002
CLERK

(3)

No. 01-1586

In the Supreme Court of the United States

LYN EVERHART,

Petitioner,

v.

ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, DOING BUSINESS AS STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY TO BRIEF IN OPPOSITION

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REASONS FOR GRANTING THE WRIT

Despite respondent's efforts to cloud the issue with extraneous factual assertions, the question presented by this petition and the question addressed by the Ninth Circuit are identical -- whether § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(1)(B), authorizes the beneficiary of an insurance policy purchased under an ERISA employee benefits plan to assert a claim for benefits against the insurance carrier. *See, Everhart v. Allmerica Financial Life Insurance Company*, 275 F.3d 751, 752 (9th Cir. 2001), Petitioner's Appendix B at 6a. That question is properly addressed by this Court on the two grounds discussed at length in the petition: (1) the existence of conflicting and confusing case law among and even within the Circuits, and (2) the existence of an important question of national importance involving the proper interpretation and application of ERISA never previously settled by this Court. Supreme Court Rule 10(a), (c). There is nothing "advisory" about such issues which have been joined in the courts below.

I. Confusion Among the Circuits

Respondent acknowledges two of the three conflicting lines of authority regarding who can be sued for ERISA plan benefits: those cases holding that only the plan itself can be sued, and later cases holding that benefits claims may be asserted against the party controlling plan administration. The first line of cases originated with *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985). The Ninth Circuit has itself questioned the continued vitality of that first line of cases in light of this Court's recent holding in *Harris Trust and Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238, 246 (2000), that ERISA "admits of no limit on

the universe of possible defendants." *Everhart,* 275 F.3d at 754, n. 3, Petitioner's Appendix B at 11a-12a.

Respondent erroneously argues that there is not a further split among the circuits by the third line of cases allowing claims against ERISA plan insurers. In each of the Third and Ninth Circuit cases cited by petitioner, implicit in the Courts of Appeals' opinions is the holding that such insurer liability must exist.[1]

In *Curcio v. John Hancock Mutual Life Insurance Co.*, 33 F.3d 226 (3d Cir. 1994), defendant John Hancock Mutual Life was sued in one capacity only -- as the issuer of an ERISA benefits insurance policy. *Id.* at 229. In determining to reverse the district court's ruling that John Hancock could be held liable for payment of those benefits, the Third Circuit performed a painstaking analysis of the policy language to determine whether coverage existed. *Id.* at 231-232. Such an analysis would have been completely unnecessary unless the Third Circuit recognized that ERISA imposed individual liability upon insurers for promised plan benefits under § 502(a)(1)(B).

The most notable of the Ninth Circuit cases allowing individual liability of an insurer is *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997), *aff'd sub nom. Humana, Inc. v. Forsyth*, 525 U.S. 299 (1999). In *Forsyth*, the panel expressly authorized a "benefits breach of contract claim under [29 U.S.C.] section 1132(a)(1) of ERISA," i.e. under § 502(a)(1)(B). *Id.* at 1475. Respondent disregards the prior

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[1] This Court recognizes such implicit holdings, including in its analysis of its own earlier decisions. *E.g., Lilly v. Virginia*, 527 U.S. 116, 134 n. 5 (1999); *United States v. Stanley*, 483 U.S. 669, 681 (1987).

history of the case in arguing that the Ninth Circuit's holding was based upon some determination that the insurer "functioned as the plan administrator." The beneficiary/plaintiffs had initially asserted two distinct ERISA claims: (1) a claim that the insurance carrier "breached its contract with them, and violated the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.*," and (2) that "the defendants violated ERISA by breaching fiduciary duties . . ." *Id.* at 1472. The district court had dismissed the breach of fiduciary duty claim, which dismissal was affirmed on appeal. *Id.* at 1475. There was no suggestion whatsoever that the court's decision was based upon any finding or assumption that the insurer had "functioned as the plan administrator."

In *Ward v. Management Analysis Company Employee Disability Benefit Plan*, 135 F.3d 1276 (9th Cir. 1998), the Ninth Circuit again permitted a benefits action against a plan's insurer, UNUM. Respondent correctly asserts that insurers sometimes provide a defense for and appear on behalf of a benefits plan, but ignores the fact that, in *Ward*, UNUM appeared not only for the plan, ***but also on behalf of itself***. *Id.* at 1279. Such a personal appearance was necessary only if there was individual liability of UNUM as an insurer. *See, also, Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998).

Respondent also cites numerous cases in an effort to imply that a "legion of cases" has determined that insurers have no ERISA benefits liability. In virtually every such case cited by respondent, however, there was no issue of an

insurer's individual liability because either the plan was self-insured[2] or no insurer of the benefits was named as a party.[3]

There is unquestionably a split of authority among the Circuits concerning who is a proper defendant in an ERISA benefits claim under § 502(a)(1)(B). The present case squarely and simply frames the issue for resolution by this Court.

II. Exceptional National Importance

Respondent fails to address this ground, independent of the split among the Circuits, that supports granting the petition. ~~The U.S.~~ Department of Labor statistics cited in the petition demonstrate without contradiction the vast number of ERISA beneficiaries, plans, and insurers that are affected by the issue presented here. The need clearly exists for this Court to clarify the application of ERISA upon insurers'

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[2] *Spain v. Aetna Life Ins. Co.*, 13 F.3d 310 (9th Cir. 1993); *Gibson v. Prudential Life Ins. Co.*, 915 F.2d 414 (9th Cir. 1990); *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279 (9th Cir. 1990); *Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir. 1996); *Auto Club Ins. Assn. v. Safeco Life Ins. Co.*, 833 F.Supp. 637, 638, 640 (W.D. Mich. 1993).

[3] *Riordan v. Commonwealth Edison Co.*, 128 F.3d 549 (7th Cir. 1997); *Hupp v. Experian Corp.*, 108 F.Supp.2d 1008 (N.D. Ill. 2000); *Holland v. Bank of America*, 673 F.Supp. 1511 (S.D. Cal. 1987); *Murphy v. Wal-Mart Assocs. Group Health Plan*, 928 F.Supp. 700 (E.D. Tex. 1996); *Crawford v. Exxon Corp.*, 851 F.Supp. 242 (M.D. La. 1994); *Holloway v. HECI Exploration Co. Employee's Profit Sharing Plan*, 76 B.R. 563 (N.D. Tex. 1987).

liability for benefits as part of the development of a uniform federal common law, as intended by Congress.

III. Insurers Are Subject to Suits for Benefits Under ERISA

Respondent asserts that § 502(d), 29 U.S.C. § 1132(d), cannot include the liability of an ERISA plan insurer, simply ignoring the express statutory language providing for "liability against such person [that] is established in his individual capacity under this subchapter." Insurers well know that, in issuing policies of insurance, they promise to provide benefits in return for the premiums they receive, and risk suit if they fail to deliver those benefits. In providing that ERISA benefits could be funded by insurance, Congress was certainly aware of the uniform national rule that insurers can be sued for benefits by the beneficiaries of insurance policies. Had Congress wished to immunize insurers from such liability, it would have done so explicitly, rather than adopting the language of § 502(d) allowing a broad range of defendants to be held liable for money judgments.

Contrary to respondent's argument, no inconsistency exists between the remedies for self-funded and insured plans, nor does this petition seek to create one. In both types of funding mechanisms, § 502(d) provides that the person responsible for payment of the benefits is subject to liability for a money judgment when those benefits are denied. In the case of a self-funded plan, the plan itself insures the benefits, and is therefore liable. In the case of an insured plan, both the plan and the insurer guarantee to the beneficiary that the promised benefits will be paid. Hence, both are liable. This liability is not any "forgotten" remedy, but was specifically intended by Congress when it authorized both that ERISA benefits could be funded by insurance and that liability would

be imposed upon any party where "established in his individual capacity." § 502(d).

Nor is this a case where petitioner seeks extracontractual damages beyond those expressly authorized by Congress. *Compare, Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). On the contrary, in §502(a)(1)(B), Congress has specifically authorized a beneficiary to file an action to recover benefits due under the terms of the plan, which is precisely what petitioner seeks. *Id.* at 146-147.

Finally, there is no risk of duplicative actions, as suggested by respondent. Under the usual joinder rules, a beneficiary would be entitled to join both the plan and the insurer in a suit for recovery of the promised benefits. Fed.R.Civ.P. 20. Similarly, a plan or insurer sued for benefits, and claiming that the other is liable for those benefits, would be entitled to bring the other into the case through a third party complaint. Fed.R.Civ.P. 14.[4] The relief petitioner requests actually promotes finality by assuring that an ERISA beneficiary may join all potential payors in a § 502(a)(1)(B) benefits action, thus advancing Congress' intent to enhance protection of the interests of plan participants and beneficiaries. *Varity v. Howe*, 516 U.S. 489, 497, 513 (1996).

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[4] There was no prior litigation here. As both parties state in their submissions, petitioner entered into a pre-litigation settlement with her deceased husband's employer.

Respectfully submitted,

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